BOARD OF DENTISTRY
DENTAL ASSISTANT REGISTRATION – LEVEL TWO

All applicants must complete every section of this application and submit the original application and all required supporting documents. If more space is needed to fully answer questions, attach additional sheets with typed responses. False or misleading statements will be cause for **disciplinary action and could be cause for criminal prosecution pursuant to *DC Code 22-2514*. If you have any questions, call HRLA Customer Service at 1-877-672-2174 Monday through Friday, 8:30 AM to 4:30 PM EST. A charge of $65.00 will be imposed for dishonored checks (Public Law 89-208)**
Please Note: Please refer to application instructions before completing this form.

SECTION 1. REGISTRATION TYPE & FEES

Please check one:

☐ New Registration $190.00

☐ Registration by Endorsement $190.00

☐ Duplication Registration Print (limit of 5) _____ X $ 34.00

CRIMINAL BACKGROUND CHECK: [A separate payment is required for each applicant]
To schedule an appointment
(Call **1-877-783-4187** or www.L1enrollment.com)
All applicants are required to undergo a Criminal Background Check

REGISTRATION EXPIRATION: All registrations **expire December 31st every** odd numbered year

For Registration Fees ONLY, make check or money order payable to: D.C. Treasurer
MAIL TO:
D.C. Department of Health
Health Regulation Licensing Administration
Board of Dentistry
P.O. Box 37801
Washington, DC 20013

Criminal Background Check Fees are separately payable to L-1 Identity Solutions

SECTION 2A. APPLICANT INFORMATION

Note: LEGAL NAME: ***(Do not use any initials unless they are a part of your name)***

_____ _____ _____ _____
FIRST NAME **MI** **LAST NAME** **(SUFFIX: Jr., Sr. etc.)**

___/_____/____ _____ - _____ - _____ *
Date of Birth **Social Security Number** **GENDER:** ☐ **MALE** ☐ **FEMALE**

***All Applicants must provide a Social Security Number (SSN). If you do not have a SSN or are waiting for one to be issued, you must submit with your application a sworn affidavit attesting that you will provide your SSN to the Board of Dentistry within 15 days of obtaining it from the government of the United States . Your registration will not be issued without a valid SSN.**

SECTION 2B. OTHER NAMES USED: (Please print clearly)

Enter your legal name exactly as it should appear on the registration. If your name on this application is different from the name on your supporting documentation provide a copy of a legal name change document. Acceptable documents for individuals are marriage certificates, divorce decrees, court orders and spouse's death certificate.

_____ _____ _____ _____
FIRST NAME **MI** **LAST NAME** **(SUFFIX: Jr., Sr. etc.)**

_____ _____ _____ _____
FIRST NAME **MI** **LAST NAME** **(SUFFIX: Jr., Sr. etc.)**

_____ _____
Place of Birth : State/Providence/Territory **Country if not USA**

SECTION 2C: RACE & ETHNICITY DESIGNATION:

☐ **American Indian/Alaskan Native**
☐ **Asian/South Asian**
☐ **Black or African American**
☐ **Caucasian/White**
☐ **Hispanic or Latino**
☐ **Other** _____
☐ **Native Hawaiian or other Pacific Islander**

LANGUAGE(S) SPOKEN:

Language(s) spoken other than English:

☐ **Spanish** ☐ **French**
☐ **German** ☐ **Arabic**
☐ **Other** _____

SECTION 3A. PREFERRED MAILING ADDRESS

Note: A P.O. BOX MAY NOT BE USED FOR AN ADDRESS. PLEASE PROVIDE A STREET ADDRESS.

Indicate your preferred mailing address by placing an "X" in the appropriate box. This will be the address to which all future registration documents will be mailed.

☐ **HOME ADDRESS** ☐ **BUSINESS ADDRESS**

SECTION 3B. HOME ADDRESS

You are statutorily required to notify the DC Board of Dentistry in writing of an address change within 30 days. Failure to do may result in your not receiving your registration, renewal notice or other official notices and can result in a disciplinary action or a fine.

☐ **Home Address or** ☐ **DC Local/Mailing Address**

ADDRESS:_____
(Street Number and Street Name) (City) (State/Province/Territory) (Zip Code)

APARTMENT #_____ **PHONE NUMBER: (**_____**)** _____ **-** _____ **FAX: (**_____**)** _____ **-** _____

EMAIL ADDRESS (REQUIRED) : _____ **CELL PHONE:** _____

SECTION 3C. BUSINESS ADDRESS

You are statutorily required to notify the DC Board of Dentistry in writing of an address change within 30 days. Failure to do may result in your not receiving your registration, renewal notice or other official notices and can result in a disciplinary action or a fine. Please note: This information will be made available to the public.

☐ **Business Address**

ADDRESS:_____
(Street Number and Street Name) (City) (State/Province/Territory) (Zip Code)

APARTMENT #_____ **PHONE NUMBER: (**_____**)** _____ **-** _____ **FAX: (**_____**)** _____ **-** _____

EMAIL ADDRESS: _____ **CELL PHONE:** _____

SECTION 4A. SCHOOLS ATTENDED

List all high schools, colleges, and universities that you have attended, beginning with the most recent at the top.

School Name, City, State, Country	Date of Graduation mm/yyyy	Degree/Certificate

SECTION 4B. PROFESSIONAL REGISTRATION/CERTIFICATION IN OTHER JURISDICTIONS

MANDATORY FIELD	JURISDICTION	ACTIVE/ NOT ACTIVE	REGISTRATION/ CERTIFICATION NUMBER
Original Registration/Certification			
Current Registration/Certification			

IMPORTANT CONTACT INFORMATION

District of Columbia Health Professional Licensing Administration
Attention: Board of Dentistry
P.O. Box 37801
Washington, D.C. 20013

Check Application Status: doh.dc.gov
HRLA Customer Service: 1-877-672-2174
Criminal Background Check (CBC) Unit Email: doh.cbcu@dc.gov **Board Email:** hplacomments@dc.gov

SECTION 5. SUPPORTING DOCUMENTS REQUIRED

Your application along with all required supporting documents must be mailed in the same package to the Board office. Please mail in a 9X12 envelope and do not staple or fold application.

Please indicate the supporting documents you have included with this package. Keep a photocopy.

☐ **Criminal Background Check (CBC) -To access form and instructions go to doh.dc.gov**
For questions contact the CBC unit at 202-442-9004.

☐ **Passport-Type Photos - Two recent and identical passport-type photos of the applicant's face (approx. 2"X2") with applicant's name printed on the back. The photos must be original photos and cannot be computer-generated copies or paper copies.**

☐ **Copy of legal document supporting name change (if applicable). Acceptable documents are marriage certificates, divorce decree, court orders or spouse's death certificate.**

☐ **SSN Affidavit (if no SSN issued)**

☐ **Verification(s) of registration/certification -- These must be provided in a sealed envelope from the issuing jurisdiction(s) for each registration/certification identified in Section 3D. *Please note: A copy of your registration/certification from another jurisdiction may not be used to verify your status.***

☐ **Valid Dental Assistant certificate from an educational program for dental assistants approved by the Board or the American Dental Association's (ADA) Commission on Dental Accreditation (CODA); or the Dental Assisting National Board (DANB); or**

☐ **Provide a detailed explanation if you answer "Yes" to any of the questions in Section 5. Submit copies of court reports, personnel actions (eg. termination due to unsafe practice), actions taken against your registration/certification or other relevant documents.**

SECTION 6A. SCREENING QUESTIONS Applicants must answer all of the following questions

A.	Have you been diagnosed or treated for substance abuse or is your ability to practice your profession impaired by alcohol or drug use?	YES ☐ NO ☐
B.	Do you have a physical or mental condition that currently impairs your ability to practice your profession?	YES ☐ NO ☐
C.	Have you ever been convicted or arrested for a crime or misdemeanor (other than a minor traffic violation)?	YES ☐ NO ☐
D.	Have you ever been terminated or asked to resign from employment or a professional training program?	YES ☐ NO ☐
E.	Please answer with respect to DC or any other jurisdiction/state:	YES NO
	(1) Have you withdrawn an application to practice your profession or voluntarily surrendered a registration/certification after formal charges have been filed against you or while under investigation?	1) ☐ ☐
	(2) Has any authority or peer review board taken adverse action against your registration/certification or privileges or informed you of any pending charges not previously reported to this Board?	2) ☐ ☐
	(3) Have you been (or are you currently being) investigated by any authority or peer review board for any violation of state, federal, or local law?	3) ☐ ☐
	(4) Has any authority or peer review board informed you of any pending charge(s) or investigation not previously reported to this Board?	4) ☐ ☐
	(5) Have you voluntarily surrendered your registration/certification?	5) ☐ ☐
	(6) Have you ever surrendered your clinical privileges or had your clinical privileges denied, revoked or suspended at any dental office or health care facility?	6) ☐ ☐
F.	Have you been party to a malpractice action or had a malpractice action brought against you?	YES ☐ NO ☐

SECTION 6B. CLEAN HANDS

Clean Hands Before Receiving a License or Permit Act of 1996 Certification Form Requirement

Please read the information below carefully before responding to this yes or no question, as **any false information provided requires that the Department of Health proceed immediately to revoke the registration** for which you are now applying, and fine you one thousand dollars ($1,000.00), pursuant to D.C. Official Code § 47-2864 (2001).

PLEASE NOTE: Pursuant to D.C. Official Code §47-2862(a) (FY 2007 Budget Support Act of 2006) you cannot be issued a registration if you have failed to file your District tax returns.

IF YOU ANSWER "YES" TO THIS QUESTION, PLEASE SUBMIT PROOF OF THE ARRANGEMENTS YOU HAVE MADE TO PAY THE OUTSTANDING DEBT. IF YOU DO NOT HAVE AN APPROVED PAYMENT SCHEDULE TO PAY THE AMOUNT YOU OWE OR IF NO APPEAL IS PENDING, THE LAW REQUIRES THAT YOUR RENEWAL APPLICATION BE DENIED.

As of this date, do you owe more than one hundred dollars ($100.00) to the District of Columbia Government as a result of any of the following:

1. Fines, penalties, or interest assessed pursuant to D.C. Official Code Title 8, Chapter 8 (Litter Control Administrative Act of 1985);
2. Fines or interest assessed pursuant to D.C. Official Code Title 8, Chapter 9 (Illegal Dumping Enforcement Act of 1994);
3. Fines, penalties, or interest assessed pursuant to D.C. Official Code Title 2, Chapter 18 (Civil Infractions Act of 1985);
4. Past due taxes;
5. Past due District of Columbia Water and Sewer Authority service fees; or
6. Fines or penalties assessed pursuant to D.C. Official Code Title 50, Chapter 23 (Traffic Adjudication)?

YES ☐ NO ☐

Information presented above is in compliance with the requirement to submit with your application for licensure under the *Clean Hands Before Receiving a License or Permit Act of 1996*, effective May 11, 1996 (D.C. Law 11-118, D.C. Code §47-2861 et seq.).

SECTION 7. REGISTRANT AFFIDAVIT

I hereby attest that the information given in this application, including all writings and exhibits attached hereto, is true and complete to the best of my knowledge. I understand that the making of a false statement on this application, including all writings and exhibits attached hereto, is punishable by criminal penalties.

_____ _____ _____

REGISTRANT SIGNATURE ***PRINT NAME*** ***DATE***

***PLEASE NOTE: PRINT AND MAIL ORIGINAL APPLICATION TO THE BOARD OF DENTISTRY AND RETAIN A COPY FOR YOUR FILES.**

To report waste, fraud, or abuse by any DC Government office or official, call the DC Inspector General at 1-800-521-1639.