

OREGON BOARD OF DENTISTRY  
UNIT 23  
PO BOX 4395  
PORTLAND, OR 97208-4395

**Application for Certification by Credential  
In Expanded Functions (Orthodontics)  
\$50.00 (Non-Refundable)**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Telephone \_\_\_\_\_

Employer: \_\_\_\_\_  
(If applicable)

Address: \_\_\_\_\_

City: \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Telephone \_\_\_\_\_

**INSTRUCTIONS**

You can **ONLY** apply for Certification by Credential in Expanded Functions (Orthodontics) if you hold a certificate from another state **or** you have worked as a dental assistant for at least 1,000 hours in a dental office within the last two (2) years, **outside** the state of Oregon, where such employment involved, to a significant extent, performing **all** Expanded Functions (Orthodontics) listed on the Pathway 1 or Pathway 2 verification forms. You must mail the application (the first two pages of this document) and fee to the address on page one (1) of the application form. **If you have not been certified or have not performed, to a significant extent, all of the expanded functions (Orthodontics) listed on these forms within the last two (2) years, you do not qualify for Certification by Credential.**

**Pathway 1 (Certified in Another State):**

Have the state in which you are currently certified submit directly to the Oregon Board of Dentistry the Verification of Certification Form (attached). Original forms must be submitted; faxes or copies are not acceptable. **This form must be submitted directly from the state, to the Oregon Board of Dentistry. Forms that are not mailed directly from the state will not be accepted.**

**or**

**Pathway 2 (1,000 hours of Clinical Practice)**

Verification of Hours: List all locations at which you practiced within the last two years, **outside of Oregon**, to verify the 1,000 hours of practice requirement. Use additional sheets if necessary.

Verification of Competence: Verification by a licensed dentist(s), **outside of Oregon**, that **you have worked at least 1,000 hours, within the last two (2) years, as a dental assistant for the dentist(s) where such employment involved to a significant extent your performing all expanded duties.** (Form attached, use additional sheets if necessary). **This form must be completed by the dentist(s) and mailed directly from the dentist(s) to the Oregon Board of Dentistry. Forms that are not mailed directly from the dentist(s) will not be accepted. Original forms must be mailed; faxes or copies are not acceptable.**

## VERIFICATION

**Pathway 1** Please list and submit copies of current licenses and/or certificates that apply:

\_\_\_\_\_  
\_\_\_\_\_

**Pathway 2** Verification of Hours: List all employers, outside of Oregon, where you have practiced at least 1,000 hours in a dental office **within the last two (2) years**, where such employment involved to a significant extent your performing **all** Expanded Functions (Orthodontics). Use additional sheets if necessary.

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Name of Dentist \_\_\_\_\_

Location/Address \_\_\_\_\_

Average hours per week \_\_\_\_\_

From \_\_\_\_\_ to \_\_\_\_\_ TOTAL \_\_\_\_\_ hours \_\_\_\_\_ years \_\_\_\_\_ months  
(Date) (Date)

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Name of Dentist \_\_\_\_\_

Location/Address \_\_\_\_\_

Average hours per week \_\_\_\_\_

From \_\_\_\_\_ to \_\_\_\_\_ TOTAL \_\_\_\_\_ hours \_\_\_\_\_ years \_\_\_\_\_ months  
(Date) (Date)

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Name of Dentist \_\_\_\_\_

Location/Address \_\_\_\_\_

Average hours per week \_\_\_\_\_

From \_\_\_\_\_ to \_\_\_\_\_ TOTAL \_\_\_\_\_ hours \_\_\_\_\_ years \_\_\_\_\_ months  
(Date) (Date)

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I certify this application is correct and that I am either certified in another state to perform the duties for which I'm applying or I have worked as a dental assistant for at least 1,000 hours in the past two years, **outside of Oregon**, where such employment involved to a significant extent my performing **all** Expanded Functions (Orthodontics).

Assistant's Signature \_\_\_\_\_ Date \_\_\_\_\_

**Verification of Certification**

Name of Dental Assistant (Please Print or Type)		
Address		
City	State	Zip
License/Certificate No.	Date Issued.	

I certify that \_\_\_\_\_  
 was granted license/certificate number \_\_\_\_\_ to perform the following orthodontic  
 expanded functions in the State of \_\_\_\_\_ on the basis of  
 successfully passing the following examination(s):

**Examination:**

Clinical examination  Yes  No  
 Written examination  Yes  No

**Expanded Functions:**

- |                          |                          |   |
|--------------------------|--------------------------|---|
| <b>Yes</b>               | <b>No</b>                |   |
| <input type="checkbox"/> | <input type="checkbox"/> | <b>Remove cement from bands using an ultrasonic or hand scaler, or a slow speed hand piece.</b> |
| <input type="checkbox"/> | <input type="checkbox"/> | <b>Recement loose orthodontic bands.</b>  |
| <input type="checkbox"/> | <input type="checkbox"/> | <b>Fit and adjust headgear.</b>   |
| <input type="checkbox"/> | <input type="checkbox"/> | <b>Remove fixed orthodontic appliances.</b>   |
| <input type="checkbox"/> | <input type="checkbox"/> | <b>Impressions.</b>   |

\_\_\_\_\_  
 Secretary

\_\_\_\_\_  
 (Date Certificate Prepared)

SEAL

Return to: Oregon Board of Dentistry  
 1500 SW 1st Avenue, Suite 770  
 Portland, Oregon 97201

**VERIFICATION OF COMPETENCE  
IN EXPANDED FUNCTIONS (ORTHODONTIC)**

**Licensed Dentist (Outside of Oregon)**

Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Telephone \_\_\_\_\_

I hereby certify that \_\_\_\_\_  
(Assistant's Name)

Has worked at least \_\_\_\_\_ hours in the last two years and is competent to perform the following orthodontic expanded functions:

**Orthodontic Expanded Functions:**

- | <b>Yes</b>               | <b>No</b>                |   |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | <b>Remove cement from bands using an ultrasonic or hand scaler, or a slow speed hand piece.</b> |
| <input type="checkbox"/> | <input type="checkbox"/> | <b>Recement loose orthodontic bands.</b>  |
| <input type="checkbox"/> | <input type="checkbox"/> | <b>Fit and adjust headgear.</b>   |
| <input type="checkbox"/> | <input type="checkbox"/> | <b>Remove fixed orthodontic appliances.</b>   |
| <input type="checkbox"/> | <input type="checkbox"/> | <b>Impressions.</b>   |

Dentist's Signature \_\_\_\_\_ Date \_\_\_\_\_

License Number \_\_\_\_\_ State \_\_\_\_\_

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