

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

**Application for Certification by Credential
 In Radiologic Proficiency
 \$75.00 (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 Radiologic Proficiency if you hold an x-ray certificate from another State Dental Board **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 your taking radiographs.

Check One Pathway Below:

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), **certificates that are not issued by a State Dental Board, do not qualify for this pathway.** Original forms must be submitted; faxes or copies are not acceptable. Forms that are not mailed directly from the state, to the Oregon Board of Dentistry, 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 taking radiographs** (Form attached, use additional sheets if necessary). **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. The 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 taking radiographs. Use additional sheets if necessary.

Name of Dentist _____

Location/Address _____

Average hours per week _____

From _____ to _____ TOTAL _____ hours _____ years _____ months
(Date) (Date)

Name of Dentist _____

Location/Address _____

Average hours per week _____

From _____ to _____ TOTAL _____ hours _____ years _____ months
(Date) (Date)

Name of Dentist _____

Location/Address _____

Average hours per week _____

From _____ to _____ TOTAL _____ hours _____ years _____ months
(Date) (Date)

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 taking radiographs.

Assistant's Signature _____ Date _____

Verification of Certification

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

I certify that the _____
(State Dental Board's name)

issued license/certificate No. _____ to _____ to take
(Name of Dental Assistant)

radiographs, on the basis of completing a course of instruction in radiologic proficiency and successfully passing the following examination(s):

Clinical examination Yes No
 Written examination Yes No

 Secretary

 (Date Certificate Prepared)

SEAL

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

VERIFICATION OF CLINICAL PRACTICE HOURS

VERIFICATION OF COMPETENCE

IN RADIOLOGIC PROFICIENCY

Licensed Dentist (Outside of Oregon)

Name of Dentist _____

Address _____

City _____ State _____ Zip _____ Telephone _____

I hereby certify that _____
(Assistant's Name)

Is competent to take radiographs and has worked at least _____ hours **for me** in the past two years where such employment involved to a significant extent taking radiographs.

Dentist's Signature _____ Date _____

License Number _____ State _____

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