COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF STATE
BUREAU OF PROFESSIONAL AND OCCUPATIONAL AFFAIRS
STATE BOARD OF DENTISTRY
P O BOX 2649
HARRISBURG, PA 17105-2649

Telephone: (717) 783-7162
Fax: (717) 787-7769
Website: www.dos.state.pa.us/dent
Email: st-dentistry@state.pa.us

APPLICATION FOR EFDA CERTIFICATION BY EXAMINATION

Please read and complete pages 1-2 of the application in their entirety. Incomplete applications will cause delay in the processing of your eligibility to sit for the examination. Instructions are as follows:

1) Complete pages 1 and 2.

2) Attach a $20.00 check or money order made payable to the "**Commonwealth of PA**". DO NOT SEND CASH. The application fee is non-refundable. Note: A $20.00 processing fee will be assessed for any payment returned by your bank, regardless of the reason for non-payment.

3) Page 3 of the application must be completed by the educational program where you have met the educational requirements under the Board's Regulations. The form must be signed by the proper official of the school, contain the school seal and be submitted **directly** to the Pennsylvania State Board of Dentistry in a sealed official school envelope. **NOTE:** If you met the requirements for, **and** had been issued a Temporary Permit, submission of page 3 of the application is not required.

You will be required to meet one of the following:

_______ A Graduated from an expanded function dental assisting program at an accredited two-year college or other accredited institution, which offers an associate degree. **Note:** The Pennsylvania State Board of Dentistry must have approved the EFDA program.

_______ B Graduated from an accredited dental hygiene program which required the successful completion of at least seventy-five (75) hours of clinical and didactic instruction in restorative functions. **Note:** The dental hygiene program must be an accredited program by the Commission on Accreditation of the American Dental Association.

_______ C Completed a certification program in expanded function dental assisting of at least two hundred (200) hours of clinical and didactic instruction from an accredited dental assisting program. **Note:** The Pennsylvania State Board of Dentistry must have approved the EFDA program.

4) A curriculum vitae of your practice activities since completion of your EFDA education. This should include employers' name, city and state, and specific job functions.

5) If you hold a license/certificate in another state as an expanded function dental assistant, contact the State Board and request a letter of good standing be submitted **directly** to the Pennsylvania State Board of Dentistry in a sealed official State Board envelope.

6) The Pennsylvania State Board of Dentistry requires each applicant for licensure, permit or certification to have a criminal background check completed within 90 days of submission to the Board. The Criminal Record Check, as well as any attachments, must be submitted with your application. The criminal background check can be obtained online using the Pennsylvania Access to the Criminal History (PATCH) System at https://epatch.state.pa.us/Home.jsp. Or, the Request for Criminal Record Check form is available online at www.psp.state.pa.us. The applicant must complete Part I of the form and mail it **directly** to the State Police at the address listed on the form. To check on the status of a request for a Pennsylvania State Police Request for Criminal Record Check call 717-783-9973. **(If you are an out-of-state applicant, you must contact the State Police from your jurisdiction.)**

7) Attach a photocopy of your current CPR certification card (front and back) in Infant, Child and Adult CPR in accordance with the Board's Regulations. The Board's Regulations are available on the website listed above.

Upon receipt and processing of all required documentation, the Board will send confirmation directly to PSI verifying your eligibility to sit for the examination. Once PSI has received confirmation from the Board, you will be sent an Eligibility Postcard from PSI. Upon receipt of the Eligibility Postcard from PSI, you will be responsible for contacting PSI to pay and schedule to take your examination. The Candidate Information Bulletin (CIB), including the examination registration form, is available on PSI's website at www.psiexams.com. Questions regarding the application from PSI or the examination must be directed to PSI. They may be reached by telephone at (800) 733-9267.

You may not practice as an expanded function dental assistant in the Commonwealth of Pennsylvania until you have successfully completed the examination and the Board has issued your EFDA certificate.

Note: Should the application not be completed within six months, updated documentation may be required. Additionally, if the application process has not been completed within one year from the date it was received, applicants will be required to submit an updated application-processing fee.

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APPLICATION FOR CERTIFICATION TO PRACTICE AS AN EXPANDED FUNCTION DENTAL ASSISTANT

1) Name ____
Last First Middle Maiden

2) Address ____
Street

____
City State Zip Code

3) Social Security Number ____________ - ____________ - ____________ *
*A U.S. Individual Taxpayer Identification Number (ITIN) or a Canadian Social Insurance Number (SIN) cannot be substituted.

4) Date of Birth ______________________________________
Month Day Year

5) Telephone # ______________________ Email ______________________

6) Do you hold a license or certificate to practice as an expanded function dental assistant, active or inactive, current or expired in any <u>other</u> state, territory or country? _____ Yes _____ No

If you answered "yes" to holding a license or certificate to practice as an expanded function dental assistant, active or inactive, current or expired in any <u>other</u> state, territory or country, please list each below:

____

7) Have you been issued a temporary permit as an expanded function dental assistant in the Commonwealth of Pennsylvania? _____ Yes _____ No

If yes, please specify your **Pennsylvania** Temporary EFDA Permit #: ______________________

Answer the following questions. If you answer **"YES"** to any of them, provide complete details on a separate sheet, as well as certified copies of relevant documents. **SIGN AND DATE BELOW.**

		YES	NO
1)	Have you ever possessed a certificate/license to practice as an expanded function dental assistant that was revoked, suspended or subjected to other disciplinary conditions?	______	______
2)	Are you, or have you ever been addicted to the excessive use of alcohol, controlled substances, chemicals or any other type of material?	______	______
3)	Have you been found guilty of a misdemeanor (other than parking or minor traffic violations) or any felony in the courts of the Commonwealth of Pennsylvania, or any other state, federal or territorial court or the courts of another country? ("been found guilty" includes a finding or verdict of guilt, an admission of guilt or a plea of nolo contendere.)	______	______

PLEASE MAKE NOTE TO THE FOLLOWING:

1) Note that disclosing your social security number on this application is mandatory in order for the State Board of Dentistry to comply with the requirements of the federal Social Security Act pertaining to child support enforcement, as implemented in the Commonwealth of Pennsylvania at 23 Pa. C.S. § 4304.1 (a). In order to enforce domestic child support orders, the Commonwealth's licensing boards must provide to the Department of Public Welfare information prescribed by DPW about the licensee, including the social security number. Additionally, disclosing the number is mandatory in order for this board to comply with the reporting requirements of the federal National Practitioner Data Bank and Healthcare Integrity and Protection Data Bank. Reports to the HIPDB must include the licensee's SSN.

2) It is your responsibility to maintain a copy of this and all documents submitted to the Board or received from the Board for your future reference.

3) Once you have passed the examination, you will receive permanent certification from the Board. EFDA certificates will expire March 31st of the odd-numbered years and are subject to renewal. In addition, 10 credit hours of acceptable continuing education will be required for each biennial period. Under the Board's Regulations, you are required to maintain current certification in infant, child and adult CPR.

CERTIFICATION STATEMENT

By signing below, I verify that this form is in the original format as supplied by the Department of State and has not been altered or otherwise modified in any way. I am aware of the criminal penalties for tampering with public records or information pursuant to 18 Pa. C.S.§4911.

Additionally, I certify that the statements in this application are true and correct to the best of my knowledge, information and belief, and that I am of good moral character. I understand that any false statement made is subject to the penalties of 18 Pa. C.S.§4904 relating to unsworn falsification to authorities and may result in the suspension or revocation of my license, permit or certificate.

Signature of Applicant: ______________________________________ Date: ________________

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APPLICATION FOR A CERTIFICATE AS AN EXPANDED FUNCTION DENTAL ASSISTANT

CERTIFICATION OF EXPANDED FUNCTION DENTAL ASSISTANT EDUCATION

PART A - ***To be completed by applicant***

NAME ____

ADDRESS ____

____

PART B – ***To be completed ONLY by the proper official of the school. (Check the one that applies)***

I certify that ______________________________ has

( ) Graduated from an expanded function dental assisting program at an accredited two-year college or other accredited institution which offers an associate degree. *(Official transcript must be attached.)*

Date of Graduation: ____________________

OR

( ) Graduated from an accredited dental hygiene program which required the successful completion of at least seventy-five (75) hours of clinical and didactic instruction in restorative functions. (*Official transcript must be attached.*)

Date of Graduation: ____________________

OR

( ) Completed a certification program in expanded function dental assisting of at least two hundred (200) hours of clinical and didactic instruction from an accredited dental assisting program. *Official transcript must be attached.)*

____
Program Director's Signature **Date**

____
Name of School

(SCHOOL SEAL)

____
Street

____
City **State** **Zip Code**

THIS FORM MUST BE COMPLETED, SIGNED, SEALED AND RETURNED DIRECTLY TO THE BOARD ALONG WITH AN OFFICIAL TRANSCRIPT IN A SEALED OFFICIAL SCHOOL ENVELOPE.