



ARIZONA STATE BOARD OF DENTAL EXAMINERS

4205 North 7th Avenue, Suite 300 • Phoenix, Arizona 85013

Telephone (602) 242-1492 • Fax (602) 242-1445

**APPLICATION FOR
DENTAL ASSISTANT RADIOGRAPHY CERTIFICATION BY CREDENTIAL**

INSTRUCTIONS: Type or print in blue or black ink. You must provide a response to each question.

1. State your legal name (Last, first, middle).

2. List other names or aliases, including maiden names, and give explanation for use.

Has your name changed for reasons other than marriage? _____ If yes, attach a certified copy of court order.

3. State your permanent address:

Street Address _____

City _____ State _____ Zip _____ Phone _____

4. State your mailing address:

Street Address _____

City _____ State _____ Zip _____ Phone _____

5. State your email address: _____

6. State your social security number (Pursuant to A.R.S. § 25-320 this is mandatory): _____

7. Date of Birth: _____ Place of Birth: _____ Sex _____ Height _____

Weight _____ Eye Color _____ Hair Color _____ Identifying Marks _____

8. List the jurisdiction, exam date and certification number or other form of approval for any other jurisdiction of the United States in which you are currently certified, previously certified, or have applied for certification in Radiation Health and Safety. For each certification listed, provide a verification of successful completion of the written and clinical dental radiograph examination(s) submitted directly from the certifying jurisdiction.

9. List any other profession in which you are or ever have been licensed or certified to practice and the state or jurisdiction issuing that license. For each license or certificate listed, provide a verification of licensure or certificate submitted directly from the licensing state.

10. Have you ever had your certificate to expose dental radiographs, or any other profession refused, denied, disciplined, suspended, revoked or cancelled by any state, territory, district or country? _____ If yes, state the full details below:

11. Do you have any medical, physical or psychological conditions that may in any way currently impair or limit your ability to safely practice? _____ If yes, please provide further information
12.
 - a. I hereby give my permission for the Arizona State Board of Dental Examiners to secure additional information concerning me or any of the statements in this application from any person or any source the Board may desire.
 - b. I further agree to submit to questioning by the Board or any member thereof, and to substantiate my statements if desired by the Board.
 - c. I will notify the Board in writing within 10 working days if charged with a misdemeanor involving conduct that may affect patient safety or a felony while I am an applicant for licensure pursuant to A.R.S. § 32-3208(B).
 - d. I intend to practice my profession in dentistry in keeping with the spirit and the letter of the Dental Practice Act of Arizona and all the laws and rules enacted in the future.
 - e. I certify that I have read all the questions on this application.
13. I, _____, the applicant herein, state and depose that all facts, statements and answers outlined in this application are true and correct; I am not omitting any information which might be of value to this Board in determining my qualifications, whether it is called for or not; and I agree that any falsification, omission, or withholding of information of facts concerning my qualifications as an applicant shall be sufficient to bar me from licensure or withholding shall serve as sufficient grounds for the revocation, cancellation, or suspension of my certification in dental radiography if it is not discovered until after issuance. A.R.S. § 32-1267

STATE OF _____

County of _____

Signature of Applicant

SUBSCRIBED AND SWORN TO before me this _____ day of _____, 20 _____.

My Commission Expires:

Notary Public

CERTIFICATION REQUIREMENTS

REQUIREMENTS:

1. LETTER OF ENDORSEMENT – A letter of endorsement must be sent directly to the Arizona State Board of Dental Examiners from the jurisdiction(s) in which you are certified in dental radiology. The letter must verify your certification and that successful completion of a written dental radiography examination was required for certification.
2. ARIZONA STATEMENT OF CITIZENSHIP – Complete the Arizona Statement of Citizenship or Alien Status for State Public Benefits form and submit copy of one or more document(s) from the "Evidence of U.S. Citizenship, U.S. National Status, or Alien Status" lists. You must submit supporting legal documentation (i.e. marriage certificate) if the name on your evidence is not the same as your current legal name. . If the document you submit does not contain a photograph, you must also provide a government issued document that contains your photograph.
3. NAME CHANGE DOCUMENTATION – If your letter of endorsement is submitted under a name other than your legal name, attach a copy of a certified document which indicates the reason for a name change.

FAILURE TO PROVIDE ANY OF THE ABOVE STATED DOCUMENTS MAY DELAY YOUR CERTIFICATION!