DENTAL ASSISTANT EXPANDED FUNCTION REQUEST INSTRUCTIONS

This application is for dental assistants who have obtained any expanded function(s) from another state and wish to see if they are eligible for expanded function(s) in the State of Oklahoma.

What to do first:

You must obtain an Oklahoma Dental Assistant Permit before you are legally authorized to work in a dental office and before you are eligible for any expanded function(s). You can find the application on our website at www.ok.gov/dentistry under the Applications and Forms tab. You may submit this request once you have obtained your permit.

Oklahoma Rules and Regulations 195:15-1-4 states that:

"Applicants who successfully complete recognized expanded duty training at a formal dental assisting program approved by the Board and the Commission on Dental Accreditation of the American Dental Association shall be eligible for permits."

Therefore, you must have completed a CODA approved Dental Assisting program in order to be eligible for any out of state expanded functions. To see if your school is CODA approved, you may go to http://www.ada.org/en/coda and click on "Find a Program." If your school is not on the list of approved programs, you will be required to retake any expanded function course(s) in the State of Oklahoma to be eligible to perform that function. You can contact the Oklahoma Dental Foundation at (405)241-1299 or visit www.okdf.org for course information.

The Committee meets quarterly, so you may not hear anything on your request for up to 3 months, depending on when the Board Office receives your request. You will be notified in writing at the address on file for you once the Committee has made a recommendation and the Board has approved the recommendation. Should the Committee approve you for expanded function(s), the Board Office will send you the appropriate application to complete. You are not authorized to perform any expanded function(s) until it reflects on your permit that is displayed in the dental office.

If you cannot or do not submit a complete packet, there is no guarantee the Committee will be able to make a recommendation to the Board. The Committee reviews your education, not your permit itself, in attempt to establish equivalency in education.

If you have any questions please contact the Board Office during normal business hours at (405)522-4844.

DENTAL ASSISTANT EXPANDED FUNCTION REQUEST

If you have received an Expanded Function permit outside of Oklahoma, please be aware that they DO NOT automatically transfer. You must be permitted through the State of Oklahoma.

$10 Per Expanded Function

Dental Assistant Name: ______________________________ Date: ____ / ____ / ____

Mailing Address: ______________________________

Daytime Phone Number: ______________ Oklahoma Dental Assistant Permit #: DA__________

Name of Dental Assistant School: ______________________________

Program State: ________ Email Address: ______________________________

What expanded function(s) are you requesting?

___ Radiation Safety and Protection
___ Coronal Polishing & Topical Fluoride
___ Pit & Fissure Sealants
___ Assisting in the Administration of Nitrous Oxide
___ Vaccinations, Venipuncture and Phlebotomy
___ Elder Care and Public Health (must have 2 years active permit)

Please attach the following documentation to this request for the Committee on Allied Dental Education to review:

☐ **Education:** The course outline on all expanded functions requested and CPR card-if assisting with Nitrous; Official transcripts-must be in a sealed envelope. Proof of a valid certificate with a minimum of (1) year

☐ **Verification of Licensure:** Contact the State Board you currently held a license.

☐ **Specific clinical experience**: Letter of recommendation from previous/current employer working for a minimum of (1) year.

☐ **Military Service:** Proof of military service of (2) years with any certifications or training in any of the certification/expanded areas; Verification from the commanding officer of the medical program or appropriate supervisor confirming functions were provided on patients for a minimum of (1) year within the past (5) years.

OKLAHOMA BOARD OF DENTISTRY

AFFIDAVIT OF DENTAL ASSISTANT

I, ______________________________ do hereby attest that the listed I have been permitted
(Dental Assistant Name and Number)
for two or more years. All information or statements made on this form(s) or any information given in connection therewith, to be true and correct. I understand and agree that this is a State of Oklahoma official document and any misrepresentation or fraudulent statement on any part of this form(s) may be grounds for disciplinary action as set forth by the Oklahoma State Dental Act 59 O.S. §Section 328.32.(A)(2), as well as other laws under the State of Oklahoma.

_______________________________________ ___________________________

Dental Assistant Signature Date

Once you have a complete packet, please mail to:

Oklahoma State Board of Dentistry
2920 N Lincoln Blvd., Ste. B
OKC, OK 73105

OKLAHOMA BOARD OF DENTISTRY
DENTISTRY