



DENTAL RADIOGRAPHY CERTIFICATION APPLICATION

(Rule 64B5-9.011, Florida Administrative Code)

SPECIAL NOTES AND INSTRUCTIONS:

1. All dentists, dental hygienists and graduates of approved dental assisting schools are exempt from certificates.
2. A **NON-REFUNDABLE fee of \$35.00 is required at application.** Please make check or money order payable to the Board of Dentistry and mail to the Department of Health, Board of Dentistry, P. O. Box 6330, Tallahassee, FL 32314-6330. If you need to send additional information that does not include a check or money order, mail it to Department of Health, Board of Dentistry, 4052 Bald Cypress Way, #C08, Tallahassee, FL 32399-3258.
3. Certification requires three (3) months continuous experience assisting in the exposing of radiographs under the **DIRECT SUPERVISION of a Florida licensed dentist** and successful completion of a Board of Dentistry approved course.
4. Attach a copy of the certificate you received from the approved course you attended. Course must have been completed within 12 months after the on-the-job training.

TO BE COMPLETED BY THE DENTAL ASSISTANT SEEKING RADIOGRAPHY CERTIFICATION:

Name: _____ Phone:() _____

Date of Birth _____ Social Security Number: Enter on next page

Address: _____

Dentist Name: _____ Phone:() _____

Address: _____

Dates of three (3) months continuous services:

From: _____ To: _____
Month Day Year Month Day Year

I HEREBY CERTIFY THAT THE ABOVE NAMED DENTAL ASSISTANT HAS BEEN IN MY EMPLOY FOR A MINIMUM OF THREE (3) MONTHS CONTINUOUS SERVICE.

SIGNATURE OF DENTIST & LICENSE NO. _____

FALSE INFORMATION IN THE APPLICATION PROCESS WILL RESULT IN APPLICATION DENIAL AND MAY RESULT IN CRIMINAL CHARGES AGAINST APPLICANT.

SIGNATURE OF DENTAL ASSISTANT: _____

Division of Medical Quality Assurance • Board of Dentistry • 4052 Bald Cypress Way, Bin #C-08
Tallahassee, FL 32399-3258 • (850) 245-4474 Telephone
www.doh.state.fl.us/mqa/dentistry

