



# OHIO STATE DENTAL BOARD RADIOGRAPHER APPLICATION

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Columbus, Ohio 43215-6135  
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dental.board@den.state.oh.us

Do Not Write In This Space

APPLICATION FORM FOR A CERTIFICATE TO PRACTICE DENTAL RADIOGRAPHY IN THE STATE OF OHIO

## DEMOGRAPHICS

*Legal Name (print)*

First Name:  Last Name:

Middle Name:  Maiden Name:

Address:  City:  State:  Zip:

Phone:  Email:  County:

Date of Birth:  Place of Birth:  City:  State:  Country:

Employer: Name:  Address:  Phone:

Social Security Number:  Sex (Male/Female):

**Social Security Number.** (This is required to facilitate reporting to the Federal Healthcare Integrity & Protection Data Bank (42 U.S.C. Section 1320a-7e(b), 5 U.S.C. Section 552a, and 45 C.F.R. pt. 61); and accurate identification under Ohio's child support enforcement law (Section 3123.50, O.R.C.). It also may be used for other investigative/enforcement purposes. Failure to provide this information will delay your licensure.

IN ORDER TO RECEIVE A CERTIFICATE TO PRACTICE DENTAL RADIOGRAPHY IN THE STATE OF OHIO, ONE OF THE FOLLOWING MUST APPLY.

## QUALIFICATIONS

**I am a Certified Dental Assistant.**

**\*\*\*REQUIRED\*\*\***

Attach a copy of your approved CDA certification, with the expiration date.

Please check mark your credential, Ohio only accepts the two below:

Dental Assisting National Board (DANB)

Commission Ohio Dental Assistant Certification (CODA)

**I have an out-of-state Dental Radiographer certificate/license.**

**\*\*\*REQUIRED\*\*\***

Attach a copy of **one of the following:**

Evidence of completion of a Board approved dental Radiographer training program.

**OR**

Evidence of 7 hours training in Radiation Physics; Radiation biology; Radiation health, safety and protection: X-ray films and radiographic film quality; Radiographic techniques, processing and storage.

**I have completed an OSDB Approved 7-hour Radiographer Course**

**\*\*\*REQUIRED\*\*\***

Attach a copy of **one of the following:**

Evidence of completion of a Board approved dental Radiographer training program.

**OR**

Evidence of 7 hours training in Radiation Physics; Radiation biology; Radiation health, safety and protection: X-ray films and radiographic film quality; Radiographic techniques, processing and storage.

**HEPATITIS B**

**Hepatitis B vaccination record**

**\*\*\*REQUIRED\*\*\***

Attach a copy of your vaccination record showing one of the following:

- All THREE legible dates.
- The 1<sup>st</sup> and 2<sup>nd</sup> dates complete with the 3<sup>rd</sup> date Scheduled  
*\*\*\*It must be a specific date on a doctor's letterhead, script pad or appointment reminder card\*\*\**

**Hepatitis B ANTIBODIES Titer**

**\*\*\*REQUIRED\*\*\***

Attach a copy of your titer; it must state one of the following:

- Positive
- Greater than 10
- Reactive

**Hepatitis B Waiver**

**\*\*\*REQUIRED\*\*\***

Attach a copy of the completed waiver.

This waiver form is found on the OSDB website.

It must be completed by a physician and include medical justification.

*This is reviewed on a case by case basis.*

**QUESTIONS**

1. Have you been convicted of or plead guilty to any felony or misdemeanor? (Exclude all traffic violations, except those involving driving while under the influence of alcohol or drugs.)? **If YES, it is REQUIRED that you provide (1) court documentation showing what the charges were, and (2) a detailed personal statement giving an explanation of those charges.**

Yes

No

2. Do you have any criminal charges pending against you? **If YES, attach a statement giving details of the matter and the name and address of the authority in possession of the record thereof.**

Yes

No

3. In the past year, have you been a patient of any sanitarium, hospital, or mental institution for the treatment of mental illness? **If YES, attach statements, giving full explanation, including name and address of doctor and institution.**

Yes

No

4. Are you engaged in the current illegal use of controlled substances, or other habit-forming drugs, or alcohol, or other chemical substances? **If YES, attach a statement giving full explanation, dates, places, etc.**

Yes

No

5. Do you have a physical or mental condition which could affect your ability to perform the duties and responsibilities of a dental assistant radiographer completely? **If YES, attach a statement giving full explanation.**

Yes

No

**Military Service (Please answer if applicable)**

- I am a member or former member of the armed forces of the United States, the National Guard or a reserve component.
- I am the spouse of a member or former member of the armed forces of the United States, the National Guard or a reserve component.

This information could be used in the future for possible benefits related to licensing and or renewal.

IT IS REQUIRED THAT A NOTARY WITNESSES YOUR SIGNATURE. NOTARIES CAN BE FOUND AT MOST FINANCIAL INSTITUTIONS.

**AFFIDAVIT**

STATE OF \_\_\_\_\_

COUNTY OF \_\_\_\_\_

I have carefully read the questions in the foregoing application and have answered them truthfully, fully and completely, without mental reservation of any kind.

I fully understand that failure to make a full disclosure of any fact or information called for may result in the denial of my application.

I hereby authorize all educational institutions, governmental agencies and instrumentalities, my references, employers and business and professional associates (past and present), to release to the Ohio State Dental Board any information, files or records requested by the Board in connection with the processing of this application.

I hereby WAIVE all provisions of law forbidding any physician or other person who has attended or examined me, or who may hereafter attend or examine me, from disclosing any knowledge or information which he/she thereby acquired, and I hereby consent that he/she may disclose such knowledge or information to the Ohio State Dental Board.

I hereby certify that I have read carefully and understand the law and rules pertaining to the practice of dentistry.

Being duly sworn, \_\_\_\_\_ says that he/she is the person referred to in this application and that the foregoing statements are true in every respect, and that the attached photograph is a true likeness of himself/herself taken within the last six (6) months.

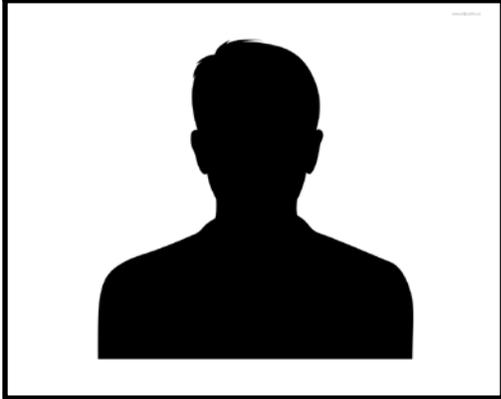
**S E A L**

Signature of Applicant \_\_\_\_\_  
Sworn to and subscribed before me this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_  
Signature of Notary \_\_\_\_\_  
Expiration Date: \_\_\_\_\_

**COLOR PASSPORT-TYPE PHOTO**

**\*\*\*REQUIRED\*\*\***

Attach color 2x2 photo below. It must not be more than 6 months old. A copy of your Driver's License Photo will **NOT** be accepted.



**APPLICATION FEE**

**\*\*\*REQUIRED\*\*\***

A non-refundable application fee of \$25.00 MUST be submitted with this application. A Check or Money order must be made out to: Treasurer, State of Ohio or Ohio State Dental Board

**APPLICATION STATUS**

You can check the status of your application online at [www.dental.ohio.gov](http://www.dental.ohio.gov) under Licensure Verification, Licensure Search Page. Only fill-in your Last Name and First Name, then click search. If your status states missing information, you will need to contact the Board.  
**It may take up to 30 days to process a complete application.**