# Ohio State Dental Board

77 South High Street, 18th Floor
Columbus, Ohio 43215-6135

Phone #: 614/466-2580
Fax #: 614/752-8995

www.dental.ohio.gov

EXPANDED FUNCTION DENTAL AUXILIARY FORM
(Dental Board Rule 4715-11-05(C))

______________________________________________, has furnished me with documented
(Name of Auxiliary)
evidence showing that he/she has successfully passed the Ohio State Dental Board designated examination for expanded function dental auxiliaries.

Said person received his/her training (explain in detail the type and location of training)

______________________________________________

______________________________________________

______________________________________________

I hereby certify that said person will be working under the direct supervision of a dentist license to practice dentistry in the State of Ohio, and further certify that said person is currently competent to perform the specific advanced remediable intra-oral dental tasks and/or procedures that I have assigned to said expanded function dental auxiliary.

I further certify that I have read and fully understand Section 4715.30 of the Ohio Revised Code, and Sections 4715-3-01 and 4715-11-05 of the Ohio Administrative Code, pertaining to expanded function dental auxiliaries.

______________________________
Employer's Name (Please print or type)

______________________________
Address

______________________________
City Zip Code

______________________________
Employer's Signature

Disposition of form:
Original to the Ohio State Dental Board, 77 South High Street, 18th Floor, Columbus, Ohio 43215-6135
Copy to be retained in your office file (subject to inspection by representatives of the Ohio State Dental Board)