Dental Radiography Certification Application

Board *of* Dentistry
4052 Bald Cypress Way, Bin C-04
Tallahassee, FL 32399-3258
Website: floridasdentistry.gov
Email: MQA.Dentistry@flhealth.gov
Phone: (850) 245-4474
Fax: (850) 921-5389

DH-MQA 1202, Revised 5/2025, Rule 64B5-9.011, F.A.C.

Are you an active-duty member of the United States Armed Services?

Are you a veteran of the United States Armed Services?

Are you the spouse of a veteran of the United States Armed Services?

Are you the spouse of an active member of the United States Armed Services?

If you answered "Yes" to any of these questions, you may qualify for a reduction in your application fees. You can find information about the Florida Department of Health's commitment to serving members and veterans of the United States Armed Forces and their families online at http://www.flhealthsource.gov/valor.

Important Information

Dental assistants who received formal training may position and expose dental and carpal radiographic film and sensors under the indirect supervision of a Florida licensed dentist. Formal training which is required for the performance of certain remediable tasks consists of successful completion of an expanded-duty course or program which meets one of the following requirements:

- The course or program is administered or was developed as part of a curriculum at a school of dentistry, dental hygiene or dental assisting accredited by the American Dental Association's Commission on Dental Accreditation, its successor agency or any other nationally recognized accrediting agency;

  OR

- The course or program has been approved by the board for the purpose of providing expanded-duties training for dental hygienists and dental assistants.

For the purpose of positioning and exposing radiographs by dental assistants, formal training may consist of having received certification as a dental radiographer pursuant to Rule 64B5-9.011, Florida Administrative Code (F.A.C.). The requirements for certification include:

- Completion of at least three months of continuous on-the-job training through assisting in the positioning and exposing of dental radiographic film under the direct supervision of a Florida licensed dentist
- Proof of successful completion of a board-approved course which meets the requirements of Rule 64B5-9.011(5), F.A.C., within 12 months after completion of the on-the-job training.

The Board of Dentistry does not issue licenses to dental assistants; however, for a list of board-approved expanded-duty/dental radiography programs, visit the "Helpful Links" section at https://floridasdentistry.gov/resources/.

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Board of Dentistry
P.O. Box 6330
Tallahassee, FL 32314-6330
Fax: (850) 921-5389
Email: MQA.Dentistry@flhealth.gov

Do Not Write in this Space
For Revenue Receipting Only

Review section (s.) 466.017(7), Florida Statutes, and Rule 64B5-9.011, Florida Administrative Code (F.A.C.), prior to submitting your application.

Dental Radiography Certification **$35.00**

Fees must be paid in the form of a cashier's check or money order, made payable to the Department of Health. Application fees are non-refundable.

1. PERSONAL INFORMATION

Name: _____ **Date of Birth:** _____
Last/Surname First Middle MM/DD/YYYY

Mailing Address: (The address where mail and your license should be sent)

_____ _____ _____
Street/P.O. Box Apt. No. City

_____ _____ _____ _____
State ZIP Country Home/Cell Telephone

Name of Employing Dentist: _____ **FL License #:** _____

Dental Practice Address:

_____ _____ _____
Street Suite No. City

_____ _____ _____
State ZIP Business Telephone

EQUAL OPPORTUNITY DATA:

We are required to ask that you furnish the following information as part of your voluntary compliance with 41 CFR Part 60-3-Uniform Guidelines on Employee Selection Procedure (1978); 43 FR 38295 and 38296 (August 25, 1978). This information is gathered for statistical and reporting purposes only and does not in any way affect your candidacy for licensure.

Gender:	Male	Race:	Native Hawaiian or Pacific Islander	Hispanic or Latino	White
	Female		American Indian or Alaska Native	Black or African American	Asian
			Two or More Races		

Email Notification: To be notified of the status of your application by email, check the "Yes" box and fill in your email address on the line provided. If you choose to be notified via email you will be responsible for checking your email regularly and updating your email address with the board office.

Yes No Email Address: _____

Under Florida law, email addresses are public records. If you do not want your email address released in response to a public records request, do not provide an email address or send electronic mail to our office. Instead contact the office by phone or in writing.

2. SOCIAL SECURITY DISCLOSURE

This information is exempt from public records disclosure.

Pursuant to Title 42 United States Code § 666(a)(13), the Department of Health is required and authorized to collect Social Security numbers relating to applications for professional licensure. Additionally, section (s.) 456.013(1)(a), Florida Statutes, authorizes the collection of Social Security numbers as part of the general licensing provisions.

Last Name: _____

First Name: _____

Middle Name: _____

U.S. Social Security Number: _____

Social Security Information- * Under the Federal Privacy Act, disclosure of Social Security numbers is voluntary unless specifically required by federal statute. In this instance, Social Security numbers are mandatory pursuant to Title 42 United States Code § 653 and 654; and s. 456.013(1), 409.2577, and 409.2598, Florida Statutes. Social Security numbers are used to allow efficient screening of applicants and licensees by a Title IV-D child support agency to ensure compliance with child support obligations. Social Security numbers must also be recorded on all professional and occupational license applications and will be used for license identification pursuant to Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Welfare Reform Act. 104 Pub. L. Section 317). Clarification of the SSA process may be reviewed at www.ssa.gov or by calling 1-800-772-1213.

Name: _____

3. EDUCATION AND TRAINING HISTORY

A. Have you graduated from a board-approved dental assisting school or program? Yes No

If "Yes," provide your graduation date: _____
MM/DD/YYYY

B. Have you had three months continuous on-the-job training assisting in positioning sensors and the positioning and exposing of radiographs under the **direct** supervision of a Florida-licensed dentist? Yes No N/A

Dates of training: From: _____ To: _____
MM/DD/YYYY MM/DD/YYY

C. After completion of the on-the-job training did you successfully complete a Board of Dentistry approved course within 12 months of completion of the on-the-job training? Yes No

Attach a copy of the certificate of completion received from the course.

4. SUPERVISING DENTIST SIGNATURE

I hereby certify that the above-named dental assistant has been in my employ for a minimum of three months continuous service and received three months of radiographic training.

Dentist Signature: _____ Date: _____
MM/DD/YYYY

Name: _____

This information is exempt from public records disclosure.

5. HEALTH HISTORY

Physical and Mental Health Disorders Impacting Ability to Practice

A. During the last two years, have you been treated for or had a recurrence of a diagnosed physical or mental disorder that impaired or would impair your ability to practice? Yes No

B. In the last two years, have you been admitted or referred to a hospital, facility or impaired practitioner program for treatment of a diagnosed mental or physical disorder that impaired your ability to practice? Yes No

Substance-Related Disorders Impacting Ability to Practice

C. During the last five years, have you been treated for or had a recurrence of a diagnosed substance-related (alcohol or drug) disorder that impaired or would impair your ability to practice? Yes No

D. During the last five years, were you admitted or directed into a program for the treatment of a diagnosed substance-related (alcohol or drug) disorder or, if you were previously in such a program, did you suffer a relapse? Yes No

E. During the last five years, have you been enrolled in, required to enter, or participated in any substance-related (alcohol or drug) recovery program or impaired practitioner program for treatment of drug or alcohol abuse? Yes No

If a "Yes" response was provided to any of the questions in this section, provide the following documents directly to the board office:

A letter from a Licensed Health Care Practitioner, who is qualified by skill and training to address the condition identified, which explains the impact the condition may have on the ability to practice the profession with reasonable skill and safety. The letter must specify that the applicant is safe to practice the profession without restrictions or specifically indicate the restrictions that are necessary. Documentation provided must be dated within one year of the application date.

A written self-explanation, identifying the medical condition(s) or occurrence(s); and current status

Name: _____

6. DISCIPLINE HISTORY

A. Have you ever been denied the right to take any health care license or certification examination in any state?
Yes No

B. Have you ever been refused a license to practice a health care profession or any other license, or the renewal thereof in any state? Yes No

C. Have you ever had a license or a certificate to practice any licensed profession revoked, suspended, or otherwise acted against (including probation, fine or reprimand) in a disciplinary proceeding in any state?
Yes No

If you responded "Yes" to any of the questions in this section, complete the following:

Name of Agency	State	Action Date (MM/DD/YYYY)	Final Action	Under Appeal?
				Y N
				Y N
				Y N
				Y N

If you responded "Yes" to any of the questions in this section, you must provide the following:

A written self-explanation, describing in detail the circumstances surrounding the disciplinary action.

A copy of the **Administrative Complaint** and **Final Order**.

7. CRIMINAL HISTORY

*For the question below, you **must include** all misdemeanors and felonies, even if adjudication was withheld. Reckless driving, driving while license suspended or revoked (DWLSR), driving under the influence (DUI) or driving while impaired (DWI) are **not** minor traffic offenses for purposes of this question.*

*Pursuant to s. 943.0585(6)(b), Florida Statutes, and s. 943.059(6)(b), Florida Statutes, an applicant seeking to be licensed by the Department of Health **must disclose** expunged and sealed criminal history records.*

Have you ever been convicted of, or entered a plea of guilty, nolo contendere, or no contest to any crime in any jurisdiction other than a minor traffic offense? Yes No

If you responded "Yes," complete the following:

Offense	Jurisdiction	Date (MM/DD/YYYY)	Final Disposition	Under Appeal?
				Y N
				Y N
				Y N

If you responded "Yes" in this section, you must provide the following:

A written self-explanation, describing in detail the circumstances surrounding each offense; including dates, city and state, charges and final results.

Final Dispositions and **Arrest Records** for all offenses. The Clerk of the Court in the arresting jurisdiction will provide you with these documents. Unavailability of these documents must come in the form of a letter from the Clerk of the Court.

Completion of Sentence Documents. You may obtain documents from the Department of Corrections. The report must include the start date, end date, and that the conditions were met.

Name: _____

8. CRIMINAL AND MEDICAID / MEDICARE FRAUD QUESTIONS

IMPORTANT NOTICE: Applicants for licensure, certification, or registration and candidates for examination may be excluded from licensure, certification, or registration if their felony convictions fall into certain timeframes as established in s. 456.0635(2), Florida Statutes.

1. Have you been convicted of, or entered a plea of guilty or nolo contendere, regardless of adjudication, to a felony under chapter (ch.) 409, Florida Statutes (relating to social and economic assistance), ch. 817, Florida Statutes (relating to fraudulent practices), ch. 893, Florida Statutes (relating to drug abuse prevention and control), or a similar felony offense(s) in another state or jurisdiction? Yes No

   If you responded "No" to the question above, skip to question 2.

   a. If "Yes" to 1, for the felonies of the first or second degree, has it been more than 15 years from the date of the plea, sentence, and completion of any subsequent probation? Yes No

   b. If "Yes" to 1, for the felonies of the third degree, has it been more than 10 years from the date of the plea, sentence, and completion of subsequent probation (this question does not apply to felonies of the third degree under s. 893.13(6)(a), Florida Statutes)? Yes No

   c. If "Yes" to 1, for the felonies of the third degree under s. 893.13(6)(a), Florida Statutes, has it been more than five years from the date of the plea, sentence, and completion of any subsequent probation? Yes No

   d. If "Yes" to 1, have you successfully completed a drug court program that resulted in the plea for the felony offense being withdrawn or the charges dismissed? Yes No

2. Have you been convicted of, or entered a plea of guilty or nolo contendere, regardless of adjudication, to a felony under 21 U.S.C. ss. 801-970 (relating to controlled substances) or 42 U.S.C. ss. 1395-1396 (relating to public health, welfare, Medicare and Medicaid issues)? Yes No

   If you responded "No" to the question above, skip to question 3.

   a. If "Yes" to 2, has it been more than 15 years before the date of application since the sentence and any subsequent period of probation for such conviction or plea ended? Yes No

3. Have you ever been terminated for cause from the Florida Medicaid Program pursuant to s. 409.913, Florida Statutes? Yes No

   If you responded "No" to the question above, skip to question 4.

   a. If you have been terminated but reinstated, have you been in good standing with the Florida Medicaid Program for the most recent five years? Yes No

Name: _____

4. Have you ever been terminated for cause, pursuant to the appeals procedures established by the state, from any other state Medicaid program? Yes No

   If you responded "No" to the question above, skip to question 5.

   a. Have you been in good standing with a state Medicaid program for the most recent five years? Yes No

   b. Did termination occur at least 20 years before the date of this application? Yes No

5. Are you currently listed on the United States Department of Health and Human Services' Office of the Inspector General's List of Excluded Individuals and Entities (LEIE)? Yes No

   a. If you responded "Yes" to the question above, are you listed because you defaulted or are delinquent on a student loan? Yes No

   b. If you responded "Yes" to question 5.a., is the student loan default or delinquency the only reason you are listed on the LEIE? Yes No

If you responded "Yes" to any of the questions in this section, you must provide the following:

A written self-explanation for each question including the county and state of each termination or conviction, date of each termination or conviction, and copies of supporting documentation.

Supporting documentation including court dispositions or agency orders where applicable.

Documents in sections 5, 6, 7, and 8 must be submitted to the board office at MQA.Dentistry@flhealth.gov, or mailed to:

Board *of* Dentistry
4052 Bald Cypress Way Bin C-04
Tallahassee, FL 32399-3258

9. APPLICANT RELEASE

I,_____, state that I am the person referred to in the foregoing Dental Radiography Certification application and supporting documentation, that said application and any supporting documentation are true and accurate.

I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past and present), business and professional associates (past and present), and all governmental agencies and instrumentalities (local, state, federal and foreign) to release to the Florida Department of Health any information, files, or records requested by the agency in connection with the processing of this application. I further authorize the Florida Department of Health to release to any organization, individual or group listed above any information which is material to my application.

I understand that it is my responsibility to supplement my application as needed to reflect any material changes in any circumstance or condition stated in the application which might affect the decision of the department and which takes place between the initial filing of the application and the final granting or denial of the dental radiography certificate.

I have carefully read the instructions and questions in the foregoing application and have answered them completely, without reservations of any kind. Should I furnish any false information in this application, or in any supporting documentation, I acknowledge that such an act constitutes cause for denial, disciplinary action, suspension or revocation of my certification to practice dental radiography under ch. 466, Florida Statutes, ch. 456, Florida Statutes, and ch. 64B5, F.A.C., in the state of Florida.

I hereby acknowledge and state that I have received, read and understood ch. 466, Florida Statutes, ch. 456, Florida Statutes, and ch. 64B5, F.A.C., and acknowledge that I must abide by them.

Applicant Signature _____ Date _____
MM/DD/YYYY