OHIO STATE DENTAL BOARD

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Columbus, Ohio 43215-6135

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PERMISSIBLE PRACTICES DOCUMENTATION FOR EXPANDED FUNCTION DENTAL AUXILIARY [EFDA]

THIS FORM AND COPIES OF ALL SUPPORTING DOCUMENTATION ATTACHED MUST BE MAINTAINED IN THE DENTAL OFFICE WHERE THE EXPANDED FUNCTION DENTAL AUXILIARY IS PRACTICING WHEN THE DENTIST IS NOT PHYSICALLY PRESENT:

SECTION 1 CERTIFICATE/REGISTRATION HOLDER INFORMATION

Name: _____ EFDA Registration #: _____

Other Names Used: _____ Dental Hygiene License #: _____

_____ Coronal Polishing Cert. #: _____

_____ Radiographer Cert. #: _____

SECTION 2 SUPERVISING DENTIST INFORMATION

Name: _____ Ohio License #: _____

Name of Practice: _____

Address: _____

_____

City: _____ State: _____ Zip Code: _____

Definition: As supervising dentist, I have evaluated the above-named expanded function dental auxiliary's skills and I have made a determination that this expanded function dental auxiliary has received the appropriate training and/or examination requirements for all permissible duties indicated on this form and is competent to perform them. I further attest that the information contained herein is true and accurate to the best of my knowledge and belief.

Name (print): _____ Date: _____

Signature: _____

SECTION 3 PRACTICE WHEN THE DENTIST IS NOT PHYSICALLY PRESENT

In order to be allowed to perform this function you **MUST** have completed a four hour Board-approved course meeting the requirements for identification and prevention of potential medical emergencies. A copy of your certificate of completion of a course meeting the requirements for identification and prevention of potential medical emergencies must be attached.

☐ I do not meet the educational/training requirements to perform this function.

☐ I have documented two years **and** 3,000 hours of experience as an expanded function dental auxiliary **and** I have successfully completed a four-hour board-approved course in the identification and prevention of potential medical emergencies through a Permanent Sponsor, subsequent to completion of my practice experience as an expanded function dental auxiliary (copy of certificate of completion attached).

COURSE

Name of **Permanent** Sponsor: Location (City, State): Date of Completion:

Course Title: _____

EMPLOYMENT HISTORY

Expanded Function Dental Auxiliary must have at least two years of active practice and at least 3,000 hours of experience in the practice as an Expanded Function Dental Auxiliary in order to be allowed to perform this function. You may make copies of this section if additional employment is required to document sufficient experience.

Name: _____ Phone #: _____

Name of Practice: _____ Dates Practiced: _____

Address: _____ Total Hours: _____

City: _____ State: _____ Zip Code: _____

Name: _____ Phone #: _____

Name of Practice: _____ Dates Practiced: _____

Address: _____ Total Hours: _____

City: _____ State: _____ Zip Code: _____

Name: _____ Phone #: _____

Name of Practice: _____ Dates Practiced: _____

Address: _____ Total Hours: _____

City: _____ State: _____ Zip Code: _____

Name: _____ Phone #: _____

Name of Practice: _____ Dates Practiced: _____

Address: _____ Total Hours: _____

City: State: Zip Code:

SECTION 4 HEPATITIS B IMMUNIZATION/INOCULATION

I certify that I have immunity to or immunization against the hepatitis B virus. Attach one or both of the following supporting documentation:

- Medical documentation reflecting dates of the hepatitis B series acceptable to the Board; and/or
- Surface antibody blood titer with results indicating positive, reactive or levels greater than 9.9.

SECTION 5 ATTESTATION

I have read the information in this form and have indicated truthfully, fully and completely those duties which I have been appropriately trained to provide in my scope of practice as a dental assistant. I further certify that I have read carefully and understand the law and rules pertaining to the practice of dental assisting, specifically regarding the aforementioned permissible duties and the education, training, examination and documentation requirements. I fully understand that falsification of any documentation may result in formal action by the Ohio State Dental Board.

Signature: _____ Date: _____

ATTENTION

THIS FORM (PAGES 1-5), ALONG WITH COPIES OF ALL SUPPORTING DOCUMENTATION ATTACHED, SHALL BE MAINTAINED IN ALL FACILITY(S) WHERE THE EXPANDED FUNCTION DENTAL AUXILIARY IS WORKING AND BE MADE AVAILABLE IMMEDIATELY UPON REQUEST.

DOCUMENTATION OF COMPLETION OF COURSES ARE YOUR PERMANENT RECORD. WITH THE EXCEPTION OF BOARD-ISSUED EXPANDED FUNCTION DENTAL AUXILIARY REGISTRATION, THE OHIO STATE DENTAL BOARD DOES NOT RECEIVE NOR RETAIN COPIES OF YOUR DOCUMENTATION.