



Ohio State Dental Board

77 South High Street, 17th Floor
Columbus, Ohio 43215-6135

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

www.dental.ohio.gov

This application packet contains all the information and application materials necessary to reinstate your certificate in the state of Ohio as a dental assistant radiographer.

Dental Assistant Radiographers seeking reinstatement of their certificate will be required to submit the following information: (A detailed checklist of step-by-step instructions is enclosed.)

- ◆ Application fee of 25.00 and Late Fee of \$15.00 (\$40.00 total);
- ◆ Copy of a Board-approved 2-hour continuing education course in dental radiography;
- ◆ Proof of immunity to or inoculation against the Hepatitis B virus;

If you have any questions concerning these instructions, please do not hesitate to call the board office.

Sincerely,

A handwritten signature in black ink, appearing to read "Lili C. Reitz". The signature is fluid and cursive, with a large, sweeping flourish at the end.

LILI C. REITZ, Esq.
Executive Director

Dental Assistant Radiographer Certificate Reinstatement Checklist

Information/documentation that MUST be submitted with your application are:

- Application Fee of \$25.00 and Late Fee of \$15.00 (\$40.00 Total);
- Copy of a Board-approved 2-hour continuing education course in dental radiography;
- Proof of immunity to or inoculation against the Hepatitis B virus;
- Ensure that you have included your Social Security Number on the application as it is required to facilitate reporting to the federal Healthcare Integrity & Protection Data Bank (42 USC Section 1320a-7e(b), 5 USC Section 552a and 45 CFR pt 61) and accurate identification under Ohio's Child Support Enforcement Law (ORC Section 3123.50). It may also be used for other investigative/enforcement purposes;
- Ensure that you have Notarized your signature on the back of the Reinstatement application; and
- Attach any supplemental documentation required for Questions 11 through 15.

Submit the Reinstatement application to the Ohio State Dental Board

Complete the Reinstatement application in its entirety and mail the application, fee, and supplemental documentation to:

Ohio State Dental Board

**77 S. High St., 17th Floor
Columbus, OH 43215-6135**



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Do Not Write In This Space
For Office Use Only

APPLICATION FORM FOR REINSTATEMENT OF DENTAL RADIOGRAPHY CERTIFICATE IN THE STATE OF OHIO

1. Present Legal Name (Print)	Last	First	Middle	Maiden (If applicable)	
2. Address	Number and Street	City	State	Zip Code	County
3. Date of Birth	Age	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Soc. Sec. No.	Certificate No.	
4. Telephone Number: Work	Telephone Number: Home	E-Mail			

PRACTICE HISTORY

5. Current Employer's Name	Period of Employment			
6. Current Employer's Address	Number and Street	City	State	Zip Code
7. Previous Employer's Name	Period of Employment			
8. Previous Employer's Address	Number and Street	City	State	Zip Code
9. Have you completed an Ohio State Dental Board approved 2-hour continuing education course in dental radiography? If YES, attach copies of Certificate of Course Completion. Course Date: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No			
10. Are you immune to or immunized against the Hepatitis B virus? If YES, attach copies of documentation.	<input type="checkbox"/> Yes <input type="checkbox"/> No			
11. Have you been convicted of or plead guilty to any felony or misdemeanor? (Exclude all traffic violations other than those involving driving while under the influence of alcohol or drugs.)? If YES, attach statement.	<input type="checkbox"/> Yes <input type="checkbox"/> No			
12. Do you have any criminal charges pending against you? If YES, attach statement giving details of the matter and the name and address of the authority in possession of the record thereof.	<input type="checkbox"/> Yes <input type="checkbox"/> No			
13. Are you now, or have you ever been a patient in 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.	<input type="checkbox"/> Yes <input type="checkbox"/> No			
14. Have you been addicted to or dependent upon alcohol or chemical substance; or been treated for, or been diagnosed as suffering from, drug or alcohol dependency or abuse? If YES, attach statement giving full explanation.	<input type="checkbox"/> Yes <input type="checkbox"/> No			
15. Do you have, or have you been diagnosed as having, a medical condition which in any way impairs, or limits your ability to practice dental assistant radiography with reasonable skill and safety? If YES, attach statement giving full explanation.	<input type="checkbox"/> Yes <input type="checkbox"/> No			

