



# Ohio State Dental Board

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

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[www.dental.ohio.gov](http://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, 17th Floor, Columbus, Ohio 43215-6135  
Copy to be retained in your office file (subject to inspection by representatives of the Ohio State Dental Board)