CERTIFICATION OF DENTAL ASSISTING EDUCATION

As part of the application process, the Iowa Dental Board requires that the school at which the applicant received her/his dental assisting education complete this form. The completed form must be mailed directly from the school to the **IOWA DENTAL BOARD.** The applicant's signature authorizes release of information, favorable or otherwise, directly to the Board.

Print Name: _____ **Date of Birth or Last 4 of SSN: _____**

Signature: _____ **Date: _____**

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This portion of the form should be completed by the school.

IT IS HEREBY CERTIFIED THAT _____
(Name of Applicant)

RECEIVED DENTAL ASSISTING EDUCATION AT_____
(Name of School)

LOCATED AT_____
(Full Address of School)

GRANTED A DEGREE/DIPLOMA IN DENTAL ASSISTING ON _____
(Month/Day/Year)

Was the school accredited by the Commission on Dental Accreditation of the American Dental Association at the time the applicant graduated? **Yes** _____ **No** _____

Did the student ever receive a warning, reprimand?* **Yes** _____ **No** _____

Was the student placed on probation or disciplined?* **Yes** _____ **No** _____

***If yes, please provide details concerning the action taken.**

President, Dean, Secretary, or Registrar:

Print Name_____ **Title**_____

Signature_____ **Date**_____

Phone #_____ **Email**_____

SCHOOL SEAL

Return completed form to:
IOWA DENTAL BOARD
400 S.W. 8th St, Suite D
Des Moines, IA 50309-4687
Phone (515) 281-5157
IDB@Iowa.gov **

**This original certification must still be sent via mail to include the school seal.