

## 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:** \_\_\_\_\_

\*\*\*\*\*

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** \_\_\_\_\_

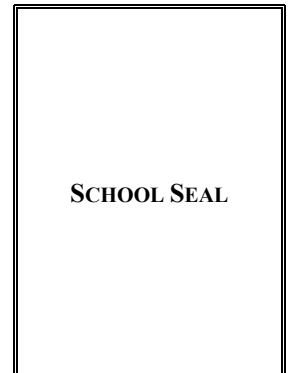
**Title** \_\_\_\_\_

**Signature** \_\_\_\_\_

**Date** \_\_\_\_\_

**Phone #** \_\_\_\_\_

**Email** \_\_\_\_\_



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](mailto:IDB@iowa.gov) \*\*

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