Iowa Dental Board
Review of Out-of-State Expanded Function Training

Name: _____

Work Address: _____

In order to qualify to train in expanded functions, you must meet one of the following requirements: (1) Minimum of three months of clinical practice as a registered dental assistant; (2) minimum three months of clinical practice in a state that does not have registration; (3) graduated from a CODA-accredited dental assistant program; (4) hold an active dental hygiene license.

	LEVEL 1 EXPANDED FUNCTIONS	COMPLETED (Y/N)	DIDACTIC TRAINING	LAB TRAINING (If applicable)	CLINICAL TRAINING	CLINICAL TRAINING	CLINICAL TRAINING	POST-COURSE TEST	DATE TRAINING COMPLETED
Instructions: Document the training & experience(s) completed by filling in the required information below. To the extent possible, indicate the dates or approximate timeframe(s) when the items were completed. Along with the date, please initial each section completed. Incomplete information may delay review of the request. If you completed training at a CODA-accredited program, please attach a copy of the syllabus or course outline.									
1	**Taking occlusal registrations**		Min. 1 hr.	**N/A**	Min. 5 patient exp. Min. 5 patient exp.	Min. 5 patient exp. Min. 5 patient exp.	Min. 5 patient exp.		
2	**Placement and removal of gingival retraction material**		Min. 2 hr.	Min. 1 hr/3 exp.	Min. 5 patient exp. Min. 5 patient exp.	Min. 5 patient exp. Min. 5 patient exp.	Min. 5 patient exp.		
3	**Fabrication, temporary cementation, and removal of provisional restorations following review of the fit and function by the supervising dentist, and temporary recementation of provisional restorations**		Min. 4 hr.	Min. 4 hr/5 exp.	Min. 10 pt exp. Min. 10 pt exp. Min. 10 pt exp. Min. 10 pt exp.	Min. 10 pt exp. Min. 10 pt exp. Min. 10 pt exp.	Min. 10 pt exp. Min. 10 pt exp. Min. 10 pt exp.		
4	**Applying cavity liners and bases and desensitizing agents**		Min. 1 hr.	Min. 1 hr/2 exp.	Min. 5 patient exp. Min. 5 patient exp.	Min. 5 patient exp. Min. 5 patient exp.	Min. 5 patient exp.		

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5	**Applying bonding systems, which may include the placement of the attachments used in clear aligner systems, following review of the fit and function by the supervising dentist**		Min. 2 hr.	Min. 1 hr/2 exp.	Min. 1 hr/2 exp. Min. 1 hr/2 exp.	Min. 5 patient exp. Min. 1 hr/2 exp.	Min. 1 hr/2 exp.		
6a	**Placement, bonding, and removal of provisional orthodontic restorations as follows: a. Placement or bonding of orthodontic brackets and bands or provisional orthodontic appliances following review of the fit and function by the supervising dentist; AND**		Min. 2 hr. ea. Function	Min. 1 hr/2 exp. ea.	Min. 5 patient exp. Min. 5 patient exp.	Min. 5 patient exp. Min. 5 patient exp.	Min. 5 patient exp.		
6b	**b. Removal of adhesive, orthodontic brackets and bands, or provisional orthodontic appliances using nonmotorized hand instrumentation**								
7	**Monitoring of patients receiving nitrous oxide inhalation analgesia**		Min. 2 hr.	Min. 1 hr.	Min. 5 patient exp. Min. 5 patient exp.	Min. 5 patient exp. Min. 5 patient exp.	Min. 5 patient exp.		
8	**Taking final impressions**		Min. 3 hr.	**N/A**	Min. 6 patient exp. Min. 6 patient exp.	Min. 6 patient exp. Min. 6 patient exp.	Min. 6 patient exp. Min. 6 patient exp.		

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9	Removal of adhesives using nonmotorized hand instrumentation		Min. 1 hr.	N/A	Min. 5 patient exp. Min. 5 patient exp.	Min. 5 patient exp. Min. 5 patient exp.	Min. 5 patient exp.		
10	Placement of temporary restorative materials following preparation of the tooth by a dentist		Min. 2 hr.	Min. 1 hr/2 exp.	Min. 5 patient exp. Min. 5 patient exp.	Min. 5 patient exp. Min. 5 patient exp.	Min. 5 patient exp.		
11	Extraoral adjustment to acrylic dentures without making any adjustments to the prosthetic teeth		Min. 1 hr.	Min. 1 hr/2 exp.	Min. 5 patient exp. Min. 5 patient exp.	Min. 5 patient exp. Min. 5 patient exp.	Min. 5 patient exp.		
12	Tissue conditioning (soft reline only)		Min. 1 hr.	Min. 1 hr/2 exp.	Min. 5 patient exp. Min. 5 patient exp.	Min. 5 patient exp. Min. 5 patient exp.	Min. 5 patient exp.		

By signing this form, I attest that I completed the expanded function training as indicated. I understand that I may only perform exanded functions in Iowa if the Iowa Dental Board approves my out-of-state training request, and I hold an active dental assistant registration or dental hygiene license. I also undertand that I must practice in accordance with Iowa Administrative Code 650.

Signature of RDA/RDH:

Name of Expanded Function Training Provider:

Signature of DDS or Training Provider:

Location of Training:

Dates Training Completed: