CERTIFICATION OF DENTAL RADIOGRAPHY TRAINING

The dental assistant's supervising dentist, who provided training in dental radiography, should complete this form.

This certifies that ________________________________ was trained in dental radiography under my supervision* and the applicant has exhibited didactic knowledge and clinical proficiency in the area of dental radiography as indicated below.

Date:		**Location**:
From (MM/DD/YYYY)	To: (MM/DD/YYYY)	(City, State)

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______________________________	______________________
Printed Name of Dentist	License #
______________________________	______________________
Dentist's Signature	Date

Return Completed Form to:
IOWA DENTAL BOARD
6200 Park Ave. #100
Des Moines, IA 50321
Phone: (515) 281-5157
IDB@iowa.gov