

Dental Assisting National Board, Inc.® (DANB®)

Request to Change a Written Exam Date or Test Site



This form must be completed by candidates who need to change a written test date or site to the next available test administration. Contact Kate Slagoski with any questions at 1-800-FOR-DANB, ext. 452. Fax this form to DANB, Attn: Kate Slagoski at 312-642-3550 or mail to:

DANB
Attn: Kate Slagoski
444 N. Michigan Ave., Suite 900
Chicago, IL 60611

DANB's Policy on Rescheduling a Written Exam Due to a Test Site Change

If a candidate is scheduled for a written exam and wishes to test at a different test site other than the one they were originally assigned, or reschedule to a different date, they must submit this form along with a \$35 rescheduling fee so that it is received

by DANB (via mail or fax) at least two weeks before the written exam date for which the candidate originally applied. The rescheduling fee of \$35 must accompany the request.

Request to Change a Written Test Site to the Next Available Testing Date

Scheduled Date and Test Site of the Exam _____

Requested Reschedule Date and Test Site _____

Please check the state exam test sites you are requesting to change.

- New Mexico Expanded Functions - Fluoride (NMXF)
- New Mexico Expanded Functions - Pit & Fissure Sealants (NMXP)
- New Mexico Expanded Functions - Coronal Polish (NMXC)
- Oregon Basic (ORB)
- Oregon Expanded Functions General (ORXG)
- Oregon Expanded Functions Orthodontic (ORXO)

Candidate Information

Name (print or type) _____ SSN _____ - _____ - _____

Name, if different, at time of exam application _____ E-mail _____

Address _____ City _____ State _____ Zip _____

Phone Number(s): Office (____) _____ Home (____) _____ Cell (____) _____ Fax (____) _____

I hereby officially request that my scheduled written examination date and/or test site location be rescheduled. **I understand a \$35 rescheduling fee is required.**

Signature _____ Date _____

Select Payment Option

Candidate's Name (print or type) _____ Candidate's SS# _____ - _____ - _____

Check/Money Order payable to the Dental Assisting National Board, Inc. or DANB

VISA MASTERCARD DISCOVER AMERICAN EXPRESS

Credit Card Authorization: Allows DANB to charge your credit card account. Please complete all information.

Credit Card Number _____ Expiration Date ____/____/____ Amount \$ _____

Cardholder's Name _____ Cardholder's Signature _____

Cardholder's Billing Address _____

City/State/Zip _____ Phone Number _____

By signing, the cardholder acknowledges purchase of the aforementioned services by DANB in the amount of the total shown hereon and agrees to perform the obligations set forth in the cardholder's agreement with the issuer. Furthermore, the cardholder understands that the signature obtained on this form shall be used to indicate receipt of purchase of the services by DANB.