

Candidate/Certificant Request for Verification



This form must be completed by individuals interested in **receiving verification of certificate(s), credential(s) or the passing status of exam(s) administered by DANB**. Contact Vickie Spears with questions at 1-800-367-3262, ext. 445. Fax this form to DANB at 312-642-8507 or mail to:

DANB
444 N. Michigan Ave., Suite 900
Chicago, IL 60611

Do NOT fax/mail twice or you will be charged twice.

DANB's Verification Policy

If a candidate has earned any certificate(s), credential(s), or passed a national DANB or state-specific exam(s), and needs or wants official verification, **he/she must submit this form along with a \$10 verification fee to DANB**. The \$10 fee covers one letter which can be used to verify multiple certificate(s), credential(s) and/or passing of an exam(s). Your verification fee is non-refundable.

An official verification is a letter to the dental assistant on DANB letterhead, verifying that the assistant passed that particular DANB national or state exam or holds a particular DANB Certification. It is *not* a duplicate certificate. **Employers requesting credential verification do not have to pay the \$10 verification fee and must fill out the employer request for verification form.**

Requesting an Official Verification

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| <ul style="list-style-type: none"> <input type="checkbox"/> Certified Dental Assistant (CDA) <input type="checkbox"/> Certified Orthodontic Assistant (COA) <input type="checkbox"/> Certified Preventive Functions Dental Assistant (CPFDA) <input type="checkbox"/> Orthodontic Assistant (OA) only <input type="checkbox"/> Certified Dental Practice Management Administrator (CDPMA) <input type="checkbox"/> Certified Oral and Maxillofacial Surgery Assistant (COMSA) <input type="checkbox"/> General Chairside (GC) only <input type="checkbox"/> Radiation Health & Safety (RHS) only <input type="checkbox"/> Infection Control (ICE) only <input type="checkbox"/> Coronal Polishing (CP) only <input type="checkbox"/> Sealants (SE) only <input type="checkbox"/> Topical Anesthetic (TA) only <input type="checkbox"/> Topical Fluoride (TF) only <input type="checkbox"/> Arizona Coronal Polishing (AZCP) <input type="checkbox"/> Arizona Radiology License <input type="checkbox"/> Delaware Dental Radiological Technology (DDRT) <input type="checkbox"/> Maryland General Expanded Functions (MDG) | <ul style="list-style-type: none"> <input type="checkbox"/> Maryland General Orthodontic Expanded Functions (MDO) <input type="checkbox"/> Missouri Basic (MOB) <input type="checkbox"/> Montana Radiology Proficiency Exam (MTRAD) <input type="checkbox"/> New Jersey Dental Radiation Technologist (NJDRT) <input type="checkbox"/> New Jersey Expanded Duties General (NJXDG) <input type="checkbox"/> New Mexico Expanded Functions Flouride (NMXF) <input type="checkbox"/> New Mexico Expanded Functions Pit & Fissure Sealant (NMXP) <input type="checkbox"/> New Mexico Expanded Functions Coronal Polish (NMXC) <input type="checkbox"/> New York Professional Dental Assisting (NYPDA) <input type="checkbox"/> Oregon Basic (ORB) Exam <input type="checkbox"/> Oregon Expanded Functions General (ORXG) Exam <input type="checkbox"/> Oregon Expanded Functions Orthodontic (ORXO) Exam <input type="checkbox"/> Oregon Expanded Functions Dental Assistant (OR EFDA) Certificate <input type="checkbox"/> Oregon Expanded Functions Orthodontic Dental Assistant (OR EFODA) Certificate <input type="checkbox"/> Oregon Radiation Proficiency Exam (OR RAD) |
|--|--|

Date Exam(s) Taken _____ Cert. # _____ SSN _____ - _____ - _____

Name (print or type) _____

Name, if different, at time of exam application _____ Email _____

Address _____ City _____ State _____ Zip _____

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

I hereby officially request a written verification by DANB that I have earned the certificate(s) and/or credential(s) or passed the exam(s) as noted above. I understand a \$10 fee (per verification letter – see DANB Policy above) is required. **Candidate/Certificant signature is required. Verification letters with payments take 1-2 weeks to process.**

Candidate/Certificant Signature _____ Date _____

Select Payment Option

Candidate/Certificant's Name _____ Cert. # or SSN _____

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

VISA MASTERCARD DISCOVER AMERICAN EXPRESS

Verification Fee:
\$10.00
Code: 3565

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.