An Iowa Dental Board Approved Course Provider

Registration Form

Complete Certified Level One Dental Assistant Expanded Functions Course

(11 Expanded Functions - 3 Day Schedule)

5965 Merle Hay Road, Suite D
P.O. Box 434
Johnston, IA 50131
www.impactdentaltraining.com
info@impactdentaltraining

Date: **April or September** **Registration Deadline:** 1 week prior to course start date

One registration page per participant. Please print clearly. *(This form may be copied for additional registrations)*

Dental Assistant First & Last Name: ______________________________

★ **Eligibility:** Year Graduated from ADA Accredited DA Program: ______ Which one? ______________

First Year Iowa RDA: ________ Year received CDA: __________ Current? Yes No

Office Name: ______________________ Sponsoring Dentist: ______________________

Contact Address: ______________________________ Apt/Unit #: ____________

City: ____________________ State: _________ Zip ___________

Work Phone: ______________________ Cell Phone: ______________________
(for last minute course information &/or changes)

Email (required): ______________________________ (you will receive email confirmation of your registration)

I am registering for:

Circle Month of Course

☐ Complete Level 1 DA Exp. Functions April September 52 CEU's $550
(11 Expanded Functions/3 Day schedule - includes all labs and post tests)

To be completed by the Dental Assistant:

I have met all minimum qualifications to participate in Expanded Functions Training as outlined in the Course Eligibility section and indicated above. I understand I must be present for the pre test and lecture in its entirety to gain credit. I also understand that the clinical/lab components of the certification process must be completed under the supervision of my sponsoring dentist and required documentation returned to Impact Dental Training prior to taking the final competency post test. I am solely responsible for meeting all requirements and deadlines of the Iowa Dental Board.

Assistant Signature: ______________________________

To be completed by the Sponsoring Dentist:

The dental assistant shown above is eligible to participate in the Expanded Function Course. I agree to sponsor her/him for the clinical/ /lab component of the certification process and to complete all required documentation accurately.

DDS Signature: ______________________________

Return registration form and check to: Impact Dental Training, PO Box 434, Johnston, IA 50131

Online registration available for credit cards or PayPal. If you have problems, let us know.

- *A $25 processing fee will be applied to all persons requesting a refund for any reason.*
- *$37 charge will be assessed to all returned checks.*

★ *Please make sure your are eligible for the course before submitting payment. Inability to take the course due to not meeting eligibility requirements will result in the $25 processing fee. If you have questions, please contact us prior to registration.*

Internal Use Only:		Scan Date:
Date Received:	Office ID:	Check # :
Email Confirm: Yes No	Deposit Date:	Signature: