Portland Area Community Health Aide Program Certification Board
Application for Dental Health Aide Certification

SUBMIT APPLICATION TO:

Northwest Portland Area Indian Health Board
Portland Area Community Health Aide Program Certification Board (PACCB)
2121 SW Broadway, Suite 300
Portland, Oregon 97201
Email: paccb@npaihb.org

INSTRUCTIONS: Please print or type information and do not use white out. Use a black or blue pen. If there is an error, please cross it out, write the correct information, initial and date any changes. This document requires the signatures of the applicant, employer, and supervising dentist. Applications may be submitted in an electronically scanned format and sent by email.

FOR OFFICIAL USE ONLY

Received

Action

1. Applicant Name: _____
(Full Legal Name) Last First MI

2. Other Names Used: _____
Last First MI

3. Date of Birth: _____
Month Day Year

4. Social Security Number (last 4 digits): _____

5. Gender (optional): ☐ Female ☐ Male ☐ Non-binary

For 6 and 7, check all that apply:

6. Ethnicity: ☐ American Indian Alaska Native ☐ First Nation

Tribal Affiliation/Citizenship: _____

☐ Hispanic ☐ Non-Hispanic

7. Race:

☐ White ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Pacific Islander

Self-identified race(s): _____

8. Home Address: _____

City: _____ State: _____ Zip: _____

9. Certification Number: _____
(If Applicable)

10. Employment Status: ☐ Full Time ☐ Part Time ☐ Itinerant ☐ Intermittent

11. Employer: _____

12. Employer Address: _____

City: _____ State: _____ Zip: _____

13. Work Phone #: _____ Fax #: _____

14. Work E-Mail:_____ Alternate email: _____

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Requirements

15. Basic Life Support Certification Expiration Date: _____

16. Dental Health Aide (DHA) Core Curriculum, if applicable: See [PACCB 7.20.010]*

Date Completed: _____and Location: _____

17. Application type (check one):

☐ Initial Certification ☐ Renewal (every 2 years)

☐ Change in Level ☐ Upgrade of Skill Set Under Current Level

18. If previously certified/licensed: Level of practice: _____

Certification/license expiration date: _____

Board providing certification/license: _____

19. Community-Based Dental Practice, if applicable. (This training is required for all PDHA II and EFDHA I or II, if they are not practicing under direct/ indirect supervision at all times, as well as, all DHAH and DHAT applicants.) See [PACCB 7.20.050]*

Date Completed: _____ Location: _____

Applying for (check one):

	Training Location	Date Training Completed	Date Preceptorship Completed
☐ **LEVEL – PDHA I**			
• Primary Oral Health Promotion/Disease Prevention See [PACCB 7.20.020]*			
• Basic Dental Procedures See [PACCB 7.20.030]*			
☐ **LEVEL – PDHA II**			
• All PDHA I See [PACCB 2.30.100-110]*			
• Advanced Dental Procedures			**NA**

See [PACCB 7.20.040]*			

One or more of the following Skill Sets:

1. Sealants See [PACCB 2.30.220]*			
2. Dental Prophylaxis See [PACCB 2.30.230]*			
3. Dental Radiology See [PACCB 2.30.240]*			
4. Atraumatic Restorative Treatment - must have completed 1-3. Se [PACCB 2.30.260]*			
5. Dental Assistant Function See [PACCB 2.30.250]*			
6. Silver Diamine Fluoride See [PACCB 2.30.270]*			
7. Antimicrobial See [PACCB 2.30.280]*			

☐ **LEVEL – EFDHA I**

(Must be a Dental Assistant) Number 1 **OR** 2 required. Numbers 3, 4, 5, 6 optional.

	Training Location	**Date Training Completed**	**Date Preceptorship Completed**
1. Basic Restorative Functions See [PACCB 7.20.200]*			
2. Dental Prophylaxis See [PACCB 2.30.230]*			

Optional Skill Sets for EFDHA I:

3. Sealants See [PACCB 2.30.220]*			
4. Dental Radiology See [PACCB 2.30.240]*			
5. Atraumatic Restorative Treatment - must have completed #2-4, #1 not required. See [PACCB 2.30.260]*			
6. Prefabricated Crowns, primary teeth - must have completed #1. See [PACCB 2.30.550]*			

☐ **LEVEL – EFDHA II**

(Must hold EFDHA I Basic Restorative Functions Certification) Number 1 required. Numbers 2, 3, 4, 5, 6 optional.

1. Advanced Restorative Functions See [PACCB 7.20.210]*			

Optional Skill Sets for EFDHA II:

2. Dental Prophylaxis See [PACCB 2.30.230]*			
3. Sealants See [PACCB 2.30.220]*			
4. Dental Radiology See [PACCB 2.30.240]*			
5. Atraumatic Restorative Treatment - must have completed #2-4. See [PACCB 2.30.260]*			
6. Prefabricated Crowns, primary teeth See [PACCB 2.30.550]*			

☐ **LEVEL – DHAH**

Graduate of an Accredited School of Dental Hygiene			**NA**

One or more of the following Skill Sets:

• Local Anesthetic See [PACCB 7.20.400]*			**NA**
• Atraumatic Restorative Treatment See [PACCB 2.30.260]*			

☐ **LEVEL – DHAT**

Graduate from Accredited School of Dental Therapy or a dental health aide therapist educational program. See [PACCB 2.30.600 (1) or (2) and 7.20.500]*			

20. For renewal of certification: Please attach documentation that renewal requirements have been completed. See [PACCB 2.50.200]*****

21. If a two-year period has passed since the DHA applied for an initial or renewal certification, attach the DHA Continuing Education Log documenting 24 hours of CE to this application. (CE is 24 contact hours of continuing education approved by the Board on varied or updated topics.) See [PACCB 3.10.050 and 3.10.200]*****

******Portland Area Community Health Aide Program Certification Board Standards and Procedures, as amended.*

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Employer Verification

22. I verify that _____ (print name of applicant):

Please **check** each item on lines 23 through 24.

23. _____ The applicant has completed the training and education requirements and is competent to practice at the level of certification being sought. The information provided on Form 2111-02d, Dental Health Aide Application, is accurate.

24. _____ The applicant is currently employed by the Indian Health Service or a tribe or tribal health program operating a community health aide program in Oregon, Washington, or Idaho, or other IHS area.

25. _____
Supervisor Name (Please Print)

26. _____
Title
(i.e.: Medical Director, Dental Chief/Director, Chief Executive Officer, or other person authorized to sign on behalf of the organization)

27. _____
Supervisor Signature

_____
Date

Please **check** item 28.

28. _____ The applicant will only practice as a DHA under the supervision of a licensed dentist, who is familiar with the DHA program, the *Standards*, and is employed by the federal government or employed by or under contract with a tribal health program operating a community health aide program in Oregon, Washington or Idaho, or other IHS area. This requirement does not preclude other dentists, and mid-level providers directing the day-to-day activities of a dental health aide under the direction of the dentist providing medical supervision.

29. _____
Supervising Dentist Name (Please Print)

30. _____
Credential

31. _____
Supervising Dentist Signature

_____
Date

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Applicant Verification

32. I verify that _____ (print name of applicant):

Please **check** each item on lines 33 through 38.

33. _____ I have received a copy of the *Portland Area Community Health Aide Program Certification Board Standards and Procedures, as amended*, and have read this document.

34. _____ I have not engaged in conduct that is grounds for imposing disciplinary sanctions under Chapter 4 of the document above.

35. _____ I have completed the training and education requirements for the level of certification requested.

36. _____ I am currently employed by the Indian Health Service or a tribe or tribal health program operating a community health aide program in Oregon, Washington, or Idaho, or other IHS area.

37. _____ I will only practice as a DHA when employed by the Indian Health Service or a tribe or tribal health program operating a community health aide program in Oregon, Washington, or Idaho, or other IHS area.

38. _____ I will only practice as a DHA under the supervision of a licensed dentist, who is familiar with the DHA program, the *Standards*, and is employed by the federal government or employed by or under contract with a tribal health program operating a community health aide program in Oregon, Washington, or Idaho, or other IHS area. This requirement does not preclude other dentists, and mid-level providers directing the day-to-day activities of a dental health aide under the direction of the dentist providing supervision.

I verify that I have considered each of the above responsibilities and have provided accurate information to the PACCB. I understand that failure to comply with any of the above provisions or providing false information may result in disciplinary action by the Board and may result in the surrender of my certificate as a DHA.

39. _____ _____
Signature of Applicant Date

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RELEASE OF INFORMATION AND VERIFYING SIGNATURE

40. I, _____ (name of applicant), authorize the Portland Area Community Health Aide Program Certification Board (PACCB) administered by the Northwest Portland Area Indian Health Board, to examine my education records and any law enforcement records pertaining to me and to discuss them with persons having possession of them. I also expressly permit and authorize release of such records pertaining to me to the PACCB.

I authorize the PACCB to discuss my records with persons or organizations, which are considered appropriate by the PACCB in connection with an official investigation, and to provide copies of my records to those persons or organizations, if appropriate.

I understand that records disclosed to the PACCB may become part of a public record and may not be protected from further disclosure by law.

This authorization is given expressly in connection with my application for certification as a Behavioral Health Aide/Practitioner. This authorization expires at the expiration of my certification.

I consent to the release of information described above and I certify under penalty of perjury that the foregoing is true and accurate.

41. _____ _____
Signature of Applicant Date

Important Notes Regarding This Application

The information contained in this application for certification and in your permanent Portland Area Community Health Aide Program Certification Board (PACCB) certification record is considered a “Public Record” and is not protected from disclosure by law. By completing this application and signing it, you are confirming the accuracy of the information entered on the application.

Your PACCB certification records may be kept in electronic, paper, and microfilm formats. You have a right to request a copy of your records at any time. Any individual has the right to inspect and copy public records under reasonable rules and during regular office hours. All requests must be made in writing. Information, which is non-disclosable, will not be made available.

It is the responsibility of the applicant to keep the PACCB informed of their current mailing and email address. The department will send correspondence, including applications for recertification, to the address on file.

If any individual believes information contained in their certification records is incorrect, the individual should notify the PACCB, in writing, of the perceived error. The address of the PACCB is:

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Portland, OR 97201
Email: paccb@npaihb.org