



Dental Assistant Sealant/Fluoride Varnish Endorsement Application Packet

Contents:

1. 642-001 Contents List/SSN Information/ Mailing Information 1 page
2. 642-007 Application Instructions Checklist 3 pages
3. 642-003 Dental Assistant Sealant/Fluoride Varnish Endorsement
Application 4 pages
4. RCW/WAC and Online Website Links..... 1 page

Important Social Security Number Information:

You are required by state and federal law to provide a social security number with your application. If you do not have a social security number at the time you send in this application, please read, complete, and return this [form](#) with your application.

A U.S. Individual Taxpayer Identification Number (ITIN) or a Canadian Social Insurance Number (SIN) cannot be substituted.

In order to process your request:

**Mail your application with initial
documentation and your check or
money order payable to:**

Department of Health
P.O. Box 1099
Olympia, WA 98507-1099

**Send other documents not sent
with initial application to:**

Dental Quality Assurance Commission
Credentialing
P.O. Box 47877
Olympia, WA 98504-7877

Contact us:

360-236-4700

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Application Instructions Checklist

Important background check Information: Washington State law authorizes the Department of Health to obtain fingerprint-based background checks for licensing purposes. This check may be through the Washington State Patrol and the Federal Bureau of Investigation (FBI). This may be required if you have lived in another state or if you have a criminal record in Washington State. This would be at your own expense.

All information should be printed clearly in blue or black ink. It is your responsibility to submit the required forms required.

Application Fee. This fee is non-refundable. You can check the online [fee page](#) for current fees.

1. Demographic Information:

Social Security Number: You must list your social security number on your application. Please call the Customer Service Center at 360-236-4700 if you do not have one.

National Provider Identifier Number (NPI): The National Provider Identifier (NPI) is a standard unique identifier for health care professionals available from the Federal Centers for Medicare and Medicaid Services. The NPI is a 10 digit numeric identifier. If you have a NPI number, provide this on your application.

Legal Name: List your full name: first, middle, and last.

Definition of legal name: “Legal name” is the name appearing on your official certificate of birth or, if your name has changed since birth, on an official marriage certificate or an order by a court. The court must have the legal authority to change your name. We may ask you to prove your legal name. If you use any name other than your legal name on this form, your application may be denied.

Birth date: Provide the month, day, and year of your birth.

Birth place: Provide the city, state and country where you were born.

Address: List the address we should use to send any information about your license. Be sure to include the city, state, zip code, county, and country. This will be your permanent address with the Department of Health until we have been notified of a change. See [WAC 246-12-310](#).

Phone, Fax, and Cell Numbers: Enter your phone, fax, and cell numbers, if you have them.

Email: Enter your email address, if you have one.

Other Name(s): Indicate whether you are known or have been known under any other names. If you have a name change, you must notify the Department of Health in writing. You must include proof of this change. See [WAC 246-12-300](#).

2. Personal Data Questions:

All applicants must answer the same personal data questions. They are focused on your fitness to practice the essential skills of this profession.

If you answer “yes” to any questions in this section, you must provide an appropriate explanation. You must also provide the documentation listed in the note after the question. If you do not provide this, your application is incomplete and it will not be considered.

- Question 5 includes misdemeanors, gross misdemeanors and felonies. You do not have to answer yes if you have been cited for traffic infractions. You can obtain copies of court records through the county courthouse where the conviction, plea, deferred sentence, or suspended sentence was entered.
- Another jurisdiction means any other country, state, federal territory, or military authority.

3. Declaration Of Training Affidavit:

Provide proof of the completion of training as contained in the Washington State Department of Health sealant/fluoride varnish program guidelines.

Applicants for endorsement must obtain the training as contained in the Washington State Department of Health sealant/fluoride varnish program guidelines, which can be met through any one of the following methods:

- a. Graduation from a dental assisting, dental hygiene or dental educational program, accredited by the American Dental Association, which has incorporated the Washington State Department of Health sealant/fluoride varnish program guidelines.
- b. Continuing education courses which teach the Washington State Department of Health sealant/fluoride varnish program guidelines.
- c. Individual training provided by a Washington licensed dentist, which has incorporated the Washington State Department of Health sealant/fluoride varnish program guidelines.

4. Affidavit of Employing/Training Dentist:

Dentist must sign and date if applicant employed by dentist after April 1, 2001, and has completed at least 200 hours of employment.

5. Applicant’s Attestation:

You must sign and date this for us to process the application.

Purpose

This endorsement is required if a dental assistant works in a school based program under a dentist's general supervision. The endorsement is not required to provide sealants in a dental office.

The dental assistant sealant/fluoride varnish endorsement program is intended to improve access to dental care for low-income, rural, and other at-risk children by enhancing the authority of dental assistants to provide dental sealant and fluoride varnish treatments in school based programs, [RCW 43.70.650](#).

- Dental assistants may work in school based programs under the “general” supervision of a Washington State licensed dentist. In settings outside of the school based programs, dental assistants must work under the “close” supervision of a Washington licensed dentist.
- Dental assistants employed by a Washington State licensed dentist on or before April 19, 2001, are not required to obtain an endorsement but may voluntarily do so without having to meet the additional requirements of [RCW 18.32.226](#).
- Dental assistants employed by a Washington State licensed dentist for 200 hours after April 19, 2001, must obtain an endorsement to provide services under this chapter. Applicants must meet the additional requirements in [RCW 18.32.226](#) and must submit (a) an application for endorsement, (b) fee, (c) proof of 200 hours of employment by a Washington State licensed dentist that has included theoretical and clinical training in the application of dental sealants and fluoride varnish treatments, verified by a declaration provided by the licensed dentist who provided the training.

Other Information

Criminal history checks are conducted for all license applicants. If you answered yes to any of the personal data questions, please submit the appropriate supporting documentation as indicated on the application. If your application is incomplete, you will be mailed a letter regarding the deficiencies.

- The application is considered incomplete if requested information is left blank. Write N/A or place a line through section instead of leaving blank.
- The initial registration will expire on your birthday unless the license is issued within 90 days of your next birthday. See [WAC 246-12-020\(3\)](#).
- A courtesy renewal notice will be mailed to your address on record. You must keep your address current with us. Any renewal postmarked or presented to the department after midnight on the expiration date is late.
- Information regarding the dental assistant program is available on our [web site](#).

Note: You cannot practice as a dental assistant until your license is issued.

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Date
Stamp
Here

Rev 0299090000

Dental Assistant Sealant/Fluoride Varnish Endorsement Application

Please print clearly. It is the responsibility of the applicant to submit or request to have submitted all required supporting documents. Failure to do so could result in a delay in processing your application.

1. Demographic Information

Social Security Number (SSN) (If you do not have a SSN, see instructions)	National Provider Identifier Number (NPI) (Enter 10 digit number)	<input type="checkbox"/> Male <input type="checkbox"/> Female
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Name	First	Middle	Last
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Birth date (mm/dd/yyyy)	Place of birth		
	City	State	Country

Address

City	State	Zip Code	County
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Country

Phone (enter 10 digit #)	Fax (enter 10 digit #)	Cell (enter 10 digit #)
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Email address

Mailing address if different from above address of record

City	State	Zip Code	County
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Country

Note: The mailing and email addresses you provide will be your addresses of record. It is your responsibility to maintain current contact information on file with the department.

Have you ever been known under any other name(s)? Yes No
If yes, list name(s):

Will documents be received in another name? Yes No
If yes, list name(s):

2. Personal Data Questions

Yes No

1. Do you have a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety? If yes, please attach an explanation.

“Medical Condition” includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, intellectual disabilities, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction, and alcoholism.

If you answered yes to question 1, explain:

1a. How your treatment has reduced or eliminated the limitations caused by your medical condition.

1b. How your field of practice, the setting or manner of practice has reduced or eliminated the limitations caused by your medical condition.

Note: If you answered “yes” to question 1, the licensing authority will assess the nature, severity, and the duration of the risks associated with the ongoing medical condition and the ongoing treatment to determine whether your license should be restricted, conditions imposed, or no license issued.

2. Do you currently use chemical substance(s) in any way which impair or limit your ability to practice your profession with reasonable skill and safety? If yes, please explain.

“Currently” means within the past two years.

“Chemical substances” include alcohol, drugs, or medications, whether taken legally or illegally.

3. Have you ever been diagnosed with, or treated for, pedophilia, exhibitionism, voyeurism or frotteurism?

4. Are you currently engaged in the illegal use of controlled substances?

“Currently” means within the past two years.

Illegal use of controlled substances is the use of controlled substances (e.g., heroin, cocaine) not obtained legally or taken according to the directions of a licensed health care practitioner.

Note: If you answer “yes” to any of the remaining questions, provide an explanation and certified copies of all judgments, decisions, orders, agreements and surrenders. The department does criminal background checks on all applicants.

5. Have you **ever** been convicted, entered a plea of guilty, no contest, or a similar plea, or had prosecution or a sentence deferred or suspended as an adult or juvenile, in Washington or another state or jurisdiction?

Note: If you answered yes, you must send certified copies of all court documents related to your criminal history with your application. If you do not provide the documents, your application is incomplete and your application will not be considered.

To protect the public, the department considers criminal history. A criminal history may not automatically bar you from obtaining a credential. However, failure to report criminal history may result in extra cost to you and the application may be delayed or denied.

2. Personal Data Questions (cont.)

Yes No

6. Have you ever been found in any civil, administrative or criminal proceeding to have:
- a. Possessed, used, prescribed for use, or distributed controlled substances or legend drugs in any way other than for legitimate or therapeutic purposes?
 - b. Diverted controlled substances or legend drugs?.....
 - c. Violated any drug law?.....
 - d. Prescribed controlled substances for yourself?
7. Have you ever been found in any proceeding to have violated any state or federal law or rule regulating the practice of a health care profession? If "yes", please attach an explanation and provide copies of all judgments, decisions, and agreements?
8. Have you ever had any license, certificate, registration or other privilege to practice a health care profession denied, revoked, suspended, or restricted by a state, federal, or foreign authority?
9. Have you ever surrendered a credential like those listed in number 8, in connection with or to avoid action by a state, federal, or foreign authority?
10. Have you ever been named in any civil suit or suffered any civil judgment for incompetence, negligence, or malpractice in connection with the practice of a health care profession?.....
11. Have you ever been disqualified from working with vulnerable persons by the Department of Social and Health Services (DSHS)?

3. Declaration Of Training Affidavit

Name of Dental Assistant (Please print)

- I was employed by a Washington State licensed dentist on or before April 19, 2001, and am voluntarily applying for the dental assistant sealant/fluoride varnish endorsement.
- I became employed by a Washington State licensed dentist after April 19, 2001, and have been employed for 200 hours. I am required to obtain this endorsement to work in a school based setting and understand I must meet the requirements of [RCW 18.32.226](#), in addition to providing the required application, fee, and proof of clinical and theoretical training in the application of sealants and fluoride varnish treatments.
- I have completed training which has incorporated the Washington State Department of Health sealant/fluoride varnish program guidelines.

Signature of Dental Assistant

Date

4. Affidavit Of Employing/Training Dentist

I hereby attest _____, as named above, became employed by me after April 1, 2001, and has completed at least 200 hours of employment.

Signature of Employing Dentist

Date

Credential #

I hereby attest that I have provided theoretical and clinical training in the application of sealants and fluoride varnish treatments to, as named above. I further attest that the training incorporated the Washington State Department of Health sealant/fluoride varnish program guidelines as described in [WAC 246-814-040\(3\)](#).

Signature of Training Dentist

Date

5. Applicant's Attestation

I, _____, declare under penalty of perjury under the laws
(Print applicant name clearly)
of the state of Washington that the following is true and correct:

- I am the person described and identified in this application.
- I have read [RCW 18.130.170](#) and [RCW 18.130.180](#) of the Uniform Disciplinary Act.
- I have answered all questions truthfully and completely.
- The documentation provided in support of my application is accurate to the best of my knowledge.
- I have read all laws and rules related to my profession.

I understand the Department of Health may require more information before deciding on my application. The department may independently check conviction records with state or federal databases.

I authorize the release of any files or records the department requires to process this application. This includes information from all hospitals, educational or other organizations, my references, and past and present employers and business and professional associates. It also includes information from federal, state, local or foreign government agencies.

I understand that I must inform the department of any past, current or future criminal charges or convictions. I will also inform the department of any physical or mental conditions that jeopardize my ability to provide quality health care. If requested, I will authorize my health providers to release to the department information on my health, including mental health and any substance abuse treatment.

Dated _____ in _____
(mm/dd/yyyy) (city, state)

By: _____
(Signature of applicant)



RCW/WAC and Online Website Links

RCW/WAC Links

[Uniform Disciplinary Act, RCW 18.130](#)

[Administrative Procedure Act, RCW 34.05](#)

[Administrative Procedures and Requirements, WAC 246-12](#)

[Dentistry Laws, RCW 18.32](#)

[Dentistry Rules, WAC 246-817](#)

[Dental Professionals Laws, RCW 18.260](#)

[Standards of Professional Conduct Rules, WAC 246-16](#)

[School Sealant Endorsement Program Laws, RCW 43.70.650](#)

[Access to Dental Care for Children Rules, WAC 246-814](#)

On-Line

[AIDS Training Resources, Reference Page](#)

[Dental Quality Assurance Commission, Web Page](#)

[Approved EFDA Education Programs, School List](#)

LISTSERV

To receive emails regarding important dental credentialing information, please join our interested parties list at, [Web Page](#)