

Radiation Safety Exam Registration

1. By submitting this form, the dentist registering the assistant certifies that the assistant is proficient in dental radiation procedures.
2. Dental Assistants moving into South Carolina from out of state: if they have their RHS from DANB they do not need to take this exam. Only out of State certificates will need to take this exam, by putting the State name in the blank for "Dentist's Full Name" put the name of the state and you will not have to complete the verification form.
3. Tests to be administered by the SCDA will be given at intervals and locations to be posted on our website <http://www.scda.org/resources/radiationsafety> . No one will be permitted to take the test until the SCDA receives a completed registration form, verification form from the employing dentist and all fees are paid in full.
4. Registration & Verification forms can be: recommended faxed *, or mailed to the office address below*, or brought to the SCDA office. Due to security, it is not recommended to be emailed.
5. Checks and Bank Cards must be submitted two week prior to the exam. Once your fees and forms have been submitted, you will be emailed your study material and video to view. One form per applicant.
6. Registrations are good for a period of six months, after which the assistant must re-register, including paying the \$60 exam fee. There are no refunds.
7. Assistants are encouraged to bring study materials to review before the test begins. Once the test begins review materials must be put away and no one will be allowed to enter or leave the room. The test may not be copied or duplicated in any manner. Test results can be reviewed by the assistant on an appointment basis at the SCDA office in Columbia.
8. NO CELL PHONE are allow in the exam room.

***RETURN TO: SCDA, 120 Stonemark Lane, Columbia, SC 29210 or *fax: 803-750-1644**

Assistant's Full Name: _____

Last 4 of Social Security Number: _____ Date of Exam _____

Email (required for study materials): _____

Address: _____ Area/Phone: _____

City: _____ State: _____ Zip: _____

Dentist's Full Name: _____

Paid by: Dentist Assistant

\$60 test registration (includes study guide & online video)

Make checks payable to the SCDA

Check # _____ Money Order # _____

Visa/MasterCard/Discover/AMEX #: _____

Name on Credit Card: _____

Exp.: _____ **vCode:** _____

Address: _____

Credit Card statement is mailed to Street, city, state, & zip

Email to send cc receipt: _____

Signature: _____ **Date:** _____

Office Use Only: Deposit# _____



Dentist Verification of Dental Assistant for Radiation Safety Training

As a dentist licensed by the South Carolina State Board of Dentistry, I certify that the following Dental Assistant has worked under my direct supervision for at least three months full-time and is proficient in dental radiation procedures.

Assistant's Name: _____
 First Initial Last

Last 4 digits Social Security # _____

Date of Hire: _____ Date of Exam: _____

Dentist's Name: _____
 First Initial Last

Dentist Signature: _____

Office Address: _____ Area/Phone: _____

City: _____ State: _____ Zip: _____