Please Print with Black or Blue Ink

Last Name: ______________________ First Name ________________ Middle Initial _____
Address __________________________ City ____________, Ohio Zip _______
Phone (Include Area Code) Home ( ) __________________ Office ( ) ______________
Date of Birth: Month __ Day ____ Year: ______ SS Number: (last 4 numbers) xxxx-xx-____
E-Mail:________________________________________________________________________

Are you currently enrolled in a Dental Assisting program? Yes____No__ Date of Completion _____________
Month Year

Name of Institution/School: _______________________________________

The exam is scheduled on a Saturday or Sunday in Spring or Fall. Applicants are accepted on a first come basis. Please check the exam you are applying for, you will be notified at least 30 days before the exam of the date for which you are scheduled.

* Examination Dates ** Application Deadline
  ____ Spring 2016 (date to be determined) January prior to exam or when exam is full
  ____ Fall 2016 (date to be determined) June prior to exam or when exam is full

* Dates may change due to the availability of the test site.

** Applications received after the deadline or if exam is full will be held for the next examination.

Type of exam applying for: (check one)

______ Full Exam: The full exam consists of three parts, Clinical, Written and Radiology*. You must pass each part of the exam to achieve Ohio Certification.

* Holding a current Radiology Certificate does not exempt applicant from taking and passing the radiology portion of the exam.

______ Retake: (check all that apply): Written _____ Clinical _____ Radiology ______
Date(s) exam previously taken: Month ____ Year ____ Applicants failing the examination three (3) times will be required to complete additional education before retaking the examination the fourth time. Examples of additional education are seminars, formal course work, or self-study courses. Evidence of completed additional education must be included with the application to take the exam for the fourth time.

Last name at time of previous exam__________________________________________

Persons with disabilities needing assistants are asked to notify the Commission at the time of application. Attach letter listing type of assistance needed: Reader___________ Extra Time _______ Other ____________
The following must be included with your application. Incomplete applications will be returned.

*Note: Applicant who has taken the exam within the last twelve months do not need to complete #2*

1. PROOF OF CURRENT CPR CERTIFICATION (MUST BE CURRENT AT TIME OF EXAM)

2. **ONE** of THE FOLLOWING NOTARIZED FORMS (ATTACH NOTARIZED FORM TO THE APPLICATION)

   A. EMPLOYER NOTARIZED RECOMMENDATION

   B. SCHOOL LIST: NOTARIZED INSTRUCTOR RECOMMENDATION
   (Use for recent graduates of or students currently enrolled in the final year of a Dental Assisting Program)

3. FEE  **Check or Money Order payable to Commission Ohio Dental Assistant Certification or CODA**
   Schools using a Purchase Order must include a copy of the PO with applications.

   ____ $65.00 Full Exam
   ____ $25.00 Retake one part  ____ $50.00 Retake two parts  ____ $65.00 Retake all parts
   ____ $20.00 Reprocessing  
   (If you have previously applied for but not taken the exam within the last 12 months)

**APPLICATIONS WILL NOT BE PROCESSED UNTIL ALL ITEMS ARE RECEIVED**

I hereby certify all information is true and I grant permission to release information pertaining to my certification status.

Signature of Applicant ___________________________ Date ________________

Questions may be mailed to the Commission at the address below or Email questions to: OhioCODAexam@aol.com

Mail Application and payment to: Commission on Ohio Dental Assistant Certification
1501 Centerview Drive  
Copley, Ohio 44321

**Attach copy of CPR here:**

**Faxed or E-mailed applications will not be accepted**