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

SUBMIT APPLICATION TO:

Alaska Native Tribal Health Consortium
Community Health Aide Program Certification Board
4000 Ambassador Drive, 4th Floor
Anchorage, Alaska 99508
Phone: (907) 729-3624/3642, Fax: (907) 729-3629, Email: chapcb@anthc.org

Instructions: Please print; use a black or blue pen only, or type information. **Do not use white out.** If an error is made, 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, by fax, or hardcopy.

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): ☐ Male ☐ Female
6. Ethnic Origin: (Optional)
   ☐ Alaska Native
   ☐ American Indian
   ☐ Asian or Pacific Islander
   ☐ Other _____
   ☐ African American
   ☐ Caucasian
   ☐ Hispanic
7. Home Address: _____
   _____
8. Certification Number: _____
   (If Applicable)
9. Employment Status: ☐ Full Time ☐ Part Time ☐ Itinerant ☐ Intermittent
10. Employer: _____
11. Employer Address: _____
    _____
12. Work Phone #: _____ Fax #: _____
13. Work E-Mail (optional): _____

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Requirements

14. BLS Certification Expiration Date: _____

15. DHA Core Curriculum, See [CHAPCB 7.20.010]*

    Date Completed: _____ and Location: _____

16. I am applying for:

    ☐ Initial Certification ☐ Renewal (every 2 years)

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

17. Village-Based Dental Practice (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 [CHAPCB 7.20.050]*

    Date Completed: _____ and Location: _____

Applying for (check one):

	Training Location	Date Training Completed	Date Preceptorship Completed
☐ **LEVEL – PDHA I**			
• Primary Oral Health Promotion/Disease Prevention See [CHAPCB 7.20.020]*			
• Basic Dental Procedures See [CHAPCB 7.20.030]*			
☐ **LEVEL – PDHA II**			
• All PDHA I See [CHAPCB 2.30.100-110]*			
• Advanced Dental Procedures See [CHAPCB 7.20.040]*			**NA**
One or more of the following Skill Sets:			
1. Sealants See [CHAPCB 2.30.220]*			
2. Dental Prophylaxis See [CHAPCB 2.30.230]*			
3. Dental Radiology See [CHAPCB 2.30.240]*			
4. Atraumatic Restorative Treatment - must have completed 1-3. See [CHAPCB 2.30.260]*			
5. Dental Assistant Function See [CHAPCB 2.30.250]*			

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

Continued on next page

Requirements continued:

☐ LEVEL – EFDHA I	Training Location	Date Training Completed	Date Preceptorship Completed
(Must be a Dental Assistant) Number 1 **OR** 2 required. Numbers 3, 4, 5, 6 optional.			
1. Basic Restorative Functions See [CHAPCB 7.20.200]*			
2. Dental Prophylaxis See [CHAPCB 2.30.230]*			
Optional Skill Sets for EFDHA I:			
3. Sealants See [CHAPCB 2.30.220]*			
4. Dental Radiology See [CHAPCB 2.30.240]*			
5. Atraumatic Restorative Treatment - must have completed #2-4, #1 not required. See [CHAPCB 2.30.260]*			
6. Stainless Steel Crowns, primary teeth - must have completed #1. See [CHAPCB 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 [CHAPCB 7.20.210]*			
Optional Skill Sets for EFDHA II:			
2. Dental Prophylaxis See [CHAPCB 2.30.230]*			
3. Sealants See [CHAPCB 2.30.220]*			
4. Dental Radiology See [CHAPCB 2.30.240]*			
5. Atraumatic Restorative Treatment - must have completed #2-4. See [CHAPCB 2.30.260]*			
6. Stainless Steel Crowns, primary teeth See [CHAPCB 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 [CHAPCB 7.20.400]*			**NA**
• Atraumatic Restorative Treatment See [CHAPCB 2.30.260]*			

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

18. For renewal of certification: Satisfactory performance under the direct supervision of a dentist, dental hygienist, or dental health aide therapist of a minimum of: (i) 80 hours, demonstrating competence in each procedure for which the dental health aide is certified, or (ii) 8 of each procedure for which the dental health aide is certified. See [CHAPCB 3.10.050(a)(1)(B)]*

Date completed: _____

19. 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 [CHAPCB 3.10.050 and 3.10.200]*

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

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Employer Verification

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

Please **check** each item on lines 21 through 23.

21. _____ 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 08-02D, Dental Health Aide Application, is accurate.

22. _____ The applicant is currently employed by the Indian Health Service or a tribe or tribal health program operating a community health aide program in Alaska under the ISDEAA [PL 93-638, 25 U.S.C. 450 et seq.].

23. _____ The application fee of $500.00 is enclosed; **or**

_____ The application fee of $500.00 will be sent separately.

NOTE: The application fee is only required for initial or renewal of certification.

Please make check payable to the Alaska Native Tribal Health Consortium – ATTN: CHAPCB

24. _____
Supervisor Name (Please Print)

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

26. _____
Supervisor Signature

_____
Date

Please **check** item 27.

27. _____ The applicant will only practice as a DHA under the supervision of a licensed dentist, who is familiar with the CHA/P program, the *Standards* and the CHAM 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 Alaska under the ISDEAA. 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.

28. _____
Supervising Dentist Name (Please Print)

29. _____
Supervising Dentist Title

30. _____
Supervising Dentist Signature

_____
Date

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Applicant Verification

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

Please **check** each item on lines 32 through 37.

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

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

34. _____ I have completed the training and education requirements for the certification requested.

35. _____ I am currently employed by the Indian Health Service or a tribe or tribal health program operating a community health aide program in Alaska under the ISDEAA [PL 93-638, 25 U.S.C. 450 et seq.].

36. _____ 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 Alaska under the ISDEAA [PL 93-638, 25 U.S.C. 450 et seq.].

37. _____ I will only practice as a DHA under the supervision of a licensed dentist, who is familiar with the CHA/P program, the *Standards* and the CHAM 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 Alaska under the ISDEAA. 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 CHAP Certification Board. 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.

38. _____ _____
Signature of Applicant Date

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RELEASE OF INFORMATION AND VERIFYING SIGNATURE

39. I, _____ (name of applicant), authorize the Indian Health Service, Community Health Aide Program Certification Board (CHAPCB), 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 Indian Health Service, CHAPCB.

    I authorize the IHS, CHAPCB to discuss my records with persons or organizations, which are considered appropriate by the IHS, CHAPCB 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 IHS, CHAPCB 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 Dental Health Aide. 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.

40. _____ _____
    Signature of Applicant Date

Important Notes Regarding This Application

The information contained in this application for certification and in your permanent Community Health Aide Program Certification Board (CHAPCB) certification record at the IHS Alaska Area Office 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 CHAPCB 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.

The $500.00 application fee will provide operational support for the CHAPCB for two years. Should operating costs be lower than anticipated, fees for future periods will be reduced accordingly.

It is the responsibility of the applicant to keep the CHAPCB informed of his or her current mailing address. The department will send correspondence, including applications for recertification, to the address on file.

If any individual believes information contained in his or her certification records is incorrect, the individual should notify the IHS, CHAPCB, in writing, of the perceived error. The address of the Board is:

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