Primary Dental Health Aide I or II
8-Procedure Recertification Checklist

DHA Name:_____ Date Completed:_____

Certification: □ PDHA I □ PDHA II

Procedures/ Skill Sets to complete:
□ Fluoride Application □ OHI □ Nutritional Counseling
□ Radiographs
□ Sealants
□ Dental Prophylaxis
□ Dental Assisting
□ Atraumatic Restorative Treatment

Supervising Provider #1 Name/ Title:_____
Supervising Provider #2 Name/Title:_____

Purpose: Completing this check off form fulfills the requirement of "completion of 8 of each procedure for which the DHA is certified, under direct supervision" for renewal of DHA certification. Only SATISFACTORY PERFOMANCE is initialed and dated. Satisfactory performance means that the DHA demonstrated the skill well enough to be entrusted to do it in a daily work situation at the time it was observed. All procedures are to be performed **satisfactory** under the direct supervision of a dentist, dental health aide therapist or dental hygienist. [CHAPCB 3.10.050 (a) (1) (B) (ii)]
To be completed by: _____

Fluoride Application

Date	Chart #	Supervising provider signature

Oral Hygiene Instruction

Date	Chart #	Supervising provider signature

Nutritional Counseling

Date	Chart #	Supervising provider signature

Radiographs

If you keep your IHS Radiology Certificate current, it will fulfill this requirement. Please attach IHS radiograph log.

Date	Chart #/ type of x-ray	Supervising provider signature

Sealants

Date	Chart #	Supervising provider signature

Dental Prophylaxis

Date	Chart #	Supervising provider signature

Dental Assisting

Date	Chart #	Supervising provider signature

Atraumatic Restorative Treatment

Date	Chart #	Supervising provider signature

SIGNATURE PAGE

I verify that I have completed the critical procedures independently, with clinical competency, and have met the minimum eight of each procedure under direct clinical observation requirement for recertification. I understand that providing false information may result in disciplinary action by the Board and may result in the surrender of my certificate as an EFDHA.

_____ _____

EFDHA Name/Signature Date

I verify that _____ (print name of applicant) has completed each of the critical procedures independently, with clinical competency, and has met the minimum eight of each procedure under direct clinical observation requirement for recertification as an Expanded Function Dental Health Aide.

_____ _____

Supervising Provider (Please Print Name) Supervising Provider Title

_____ _____

Supervising Provider Signature Date