COMMISSION OHIO DENTAL ASSISTANT CERTIFICATION
Examination Application

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 the fall and spring each year. Please check the exam you are applying for, you will be notified 30 to 60 days before the exam of the date for which you are scheduled.

Examination Dates	Application Deadline (see note below)
____ Spring (date to be determined)	January prior to exam
____Fall (date to be determined)	June prior to exam

NOTE: Applicants are accepted on a first come basis. 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 reason for request and type of assistance needed. Please be specific regarding the type of assistance needed: Reader___Extra Time___Other____

The following must be included with your application. Incomplete applications will be returned.

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)

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

A. EMPLOYER NOTARIZED RECOMMENDATION

B. SCHOOL LIST: NOTARIZED INSTRUCTOR RECOMMENDATION
(Use for recent graduates 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 PROCESED 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