STATE OF MAINE BOARD OF DENTAL PRACTICE
CERTIFICATE OF EFDA COMPLETION FORM

I am applying to obtain a license to practice as an Expanded Function Dental Assistant with the Maine Board of Dental Practice ("the Board"). The Board requires verification of successful completion of a training and/or program in expanded function dental assisting approved by the Board. This is your authority to release any information in your files directly to the Board.

THIS SECTION TO BE COMPLETED BY THE APPLICANT.

Applicant's name: _____

Applicant's address: _____

Dates of attendance: from_____to_____

Applicant's signature_____date: _____

THIS SECTION MUST BE COMPLETED BY AN AUTHORIZED REPRESENTATIVE OF THE TRAINING PROGRAM OR EDUCATIONAL INSTITUTION AND RETURNED DIRECTLY TO THE MAINE BOARD OF DENTAL PRACTICE.

I hereby certify that the above-named applicant successfully completed an expanded function dental assisting training and/or program.

Name of EFDA training/program:_____

Name of school/organization: _____

Address of school/organization:_____

Dates of attendance: from_____to_____

Printed name & title of authorized representative: _____

Official's signature_____date: _____

PLACE OFFICIAL EMBOSSED SCHOOL/ORGANIZATION SEAL HERE

Once completed, the authorized representative must submit a scanned original copy directly to the Maine Board of Dental Practice in a pdf format and email to: dental.board@maine.gov