Verification of Out-of-State Clinical Experience and Competency in Performing Dental Radiographic Procedures

(Item # 5 of the Appendix of New Jersey Examination/License Application)

Clinical Experience CANNOT be obtained in New Jersey

1. Location of Clinical Experience:

Office Name:
Address:
Telephone Number:

2. **Length of clinical experience in dental radiography:** From :____________To: ___________

3. Please check the type(s) of dental radiographic procedures that were performed by this applicant:

Intraoral (Paralleling Technic)	Intraoral (Bisecting Angle Technic)
Occlusal	Panoramic

Other: Please List:

4. Imaging system used:

Film	Digital	Both

5. **Dentist Attestation of Competence**:

I, Dr.________________________________attest that_____________________________has
(Print the full name of the dentist) *(Print the name of the applicant)*
demonstrated competency in all clinical objectives listed below on patients while performing the above marked procedures:

Greet patient and explain and verify the radiographic procedure to be performed
Review patient's medical history and record of previous exposures
Evaluate the area to be exposed to determine that all dentures, jewelry and other unnecessary objects are removed
Use radiation protection practices for patient, self and others
Position the patient for requested radiographs
Position the image receptor to record the area of interest
Position the x-ray equipment for desired exposure
Select exposure factors and make x-ray exposure
Produce radiographic images that are free from artifacts and other errors
Mount films or display digital images and properly identify radiographs using the ADA recommended method

______________________________________ ______________
Dentist Signature Date