

Dental Assistant

REIMBURSEMENT REQUEST INFO



Bright Futures in Dentistry accepts Dental Assistant Reimbursement requests for the following:

- **Dental Assisting National Board (DANB) Exams**
 - Three-part DANB CDA Exams
 - Three-part DANB NELDA Exams
- **DANB/DALE Foundation Prep Materials**
 - Review courses and/or practice tests
- **DA Prep**
 - Dentist Sponsored Online Course
 - New Assistant Online Course

TOTAL REIMBURSEMENT TO BE GRANTED, PER INDIVIDUAL, NOT TO EXCEED \$1,750.00

Required Documents

1. Reimbursement Form
2. North Dakota QDA/RDA Registration Certificate.
3. All applicable receipts (name on receipts must match reimburse)
4. W9

Please email the documents listed above to Admin@NDDental.org to be considered

Timeline for Reimbursement Request Processing

Once we receive your application and supporting documents, our committee will thoroughly review them. Please allow up to two weeks for us to reach a decision and notify you accordingly. If your reimbursement request is approved, you can expect to receive a check within one month of submitting the request.

Additional Information

- Reimbursement requests should be made within 90 days of course/exam completion.
- Anticipate being contacted by one of our committee members to provide a biennial update regarding your Dental Assistant career.

Acknowledging the Contributions of Our Phenomenal Donors

We'd like to express our heartfelt gratitude to our incredible donors, who have been the driving force behind the success of this program. We'd be delighted to share your story with them! If you're interested, please send us an email at Admin@NDDental.org. Kindly include a brief quote on your motivation for becoming a DA and how this program has impacted your life, along with a captivating photo of yourself in action.



Dental Assistant

REIMBURSEMENT REQUEST FORM



Chairside-Trained Dental Assistant

Date: _____
 Full Name: _____
 Address: _____
 City: _____ State: _____ Zipcode: _____
 Phone: _____ Email: _____
 ND QRA/RDA Lic# _____

Dental Clinic

Office Name: _____
 Primary Contact: _____
 Address: _____
 City: _____ State: _____ Zipcode: _____
 Email: _____

Instructions: 1. Check the box for who and what should be reimbursed. 2. Complete W9.
 3. Attach all receipts. 4. Email: Admin@NDDental.org

Chairside-Trained Dental Assistant

Dental Clinic

Description of Reimbursement

Amount

<input type="checkbox"/> DANB Exams <input type="checkbox"/> General Chairside <input type="checkbox"/> RHS <input type="checkbox"/> ICE	Dates Taken _____ _____ _____	_____ _____ _____
<input type="checkbox"/> NELDA Exams <input type="checkbox"/> AMP <input type="checkbox"/> RHS <input type="checkbox"/> ICE	Dates Taken _____ _____ _____	_____ _____ _____
<input type="checkbox"/> DA Prep Course <input type="checkbox"/> Dentist Sponsored <input type="checkbox"/> New Assistant	Dates Taken _____ _____	_____ _____
<input type="checkbox"/> DANB/DALE Foundation Review and Prep Materials		

TOTAL _____

(Total reimbursement to be granted, per individual, not to exceed \$1,750.00)

