



E|F|D|A
EXPANDED FUNCTIONS
DENTAL ASSISTANT



**Request for
Duplicate
Certificate**

Duplicate certificates or certificates reflecting a change of name may be requested of the Missouri Dental Association. *Only the individual who is certified may submit the request.* **The fee is \$20 per certificate.** **Please complete below and fax/mail with payment. Allow 7-10 for certificate to be sent.**

**THIS IS NOT A REQUEST FOR DUPLICATE EFDA PERMITS.
PERMITS ARE ISSUED BY THE MISSOURI DENTAL BOARD (573-751-0040).**

REGISTRANT INFORMATION			
Full Name (as originally certified)			
Certificate Name (if different than above)			
Phone Number		Email Address	
Mailing Address		City, State, Zip	
COURSE INFORMATION			
<i>If the course was not an MDA-sponsored course (taken at OTC, Nichols Career Center or Other), please</i>			
Course Taken	<input type="checkbox"/> Restorative I	<input type="checkbox"/> Restorative II	<input type="checkbox"/> Orthodontic <input type="checkbox"/> Fixed Pros <input type="checkbox"/> Remov Pros
Date Taken	____/____/____	Course Location	
Course Taken	<input type="checkbox"/> Restorative I	<input type="checkbox"/> Restorative II	<input type="checkbox"/> Orthodontic <input type="checkbox"/> Fixed Pros <input type="checkbox"/> Remov Pros
Date Taken	____/____/____	Course Location	
Course Taken	<input type="checkbox"/> Restorative I	<input type="checkbox"/> Restorative II	<input type="checkbox"/> Orthodontic <input type="checkbox"/> Fixed Pros <input type="checkbox"/> Remov Pros
Date Taken	____/____/____	Course Location	
PAYMENT			
Total Amount Due \$	<input type="checkbox"/> Credit Card (VISA/MC/DISC)		<input type="checkbox"/> Check (Payable to MDA)
Card Number		Exp Date	CSV
Name on Card		Signature	
ADA Membership #			
Phone		Email	
CREDIT CARD BILLING ADDRESS <i>Provide only if paying by credit card</i>			
Address			
City		State	Zip
SHIPPING ADDRESS <i>Provide only if you want items shipped to address DIFFERENT from credit card</i>			
Address			
City		State	Zip

FAX OR MAIL CREDIT CARD PAYMENTS / MAIL FORM & CHECK PAYMENTS

Missouri Dental Association, 3340 American Ave, Jefferson City, MO 65109
Fax 573-635-0764 Questions: 573-634-3436 or mandy@modentalmail.org