

COMMONWEALTH OF VIRGINIA
VIRGINIA BOARD OF DENTISTRY
9960 MAYLAND DRIVE, SUITE 300
HENRICO, VA 23233-1463
804-367-4538
www.dhp.virginia.gov/dentistry

A completed application shall include the following unless stated below. An incomplete application and/or fee will delay the processing of your application. Incomplete applications are kept for one year then destroyed.

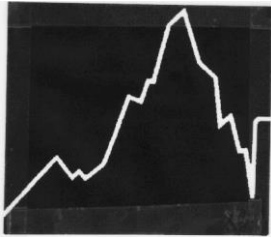
APPLICATION INSTRUCTIONS FOR REINSTATEMENT OF REGISTRATION AS A DENTAL ASSISTANT II:

- _____ **1.Reinstatement Application:** Please be sure that all information is completed on the application.
- _____ **2.Fee for applicant due to lapse of license:** The reinstatement fee for a **Dental Assistant II Registration** is \$125 and must be paid with a certified check, cashier's check or money order, made payable to the **Treasurer of Virginia**. The fee can be used for one year from date of receipt. Pursuant to 18VAC60-30-30(F), all fees are non-refundable. Your application will not be reviewed until you have submitted payment.
- Fee for applicant due to previously revoked or indefinitely suspended license:** The reinstatement fee for a previously revoked Dental Assistant II registration is **\$300** and the reinstatement fee for a previously indefinitely suspended Dental Assistant II registration is **\$250**.
- _____ **5.Form C:** Original licensure verification from any jurisdiction in which you currently hold or have ever held a license/registration/certification to practice as a dental assistant or as another health care professional **and** certification of authorization to perform expanded duties as a dental assistant. Copies of permits are not accepted. Verification cannot be older than 6 months from date prepared.
- _____ **6.Evidence of a current credential as a **Certified Dental Assistant** (CDA) conferred by the Dental National Board (DANB) or another certification from a credentialing organization recognized by the American Dental Association and acceptable to the board.**
- _____ **7.Evidence of Continuing Clinical Competence:** The applicant must include documentation in the application sufficient to demonstrate continuing clinical competence in the duties for which the applicant is requesting reinstatement of, which may include documentation of active practice in another state or in federal service, or a refresher course offered by an educational program accredited by the Commission on Dental Accreditation of the American Dental Association.
- _____ **8.Name Change:** Documentation must be provided to show each name change(s) if your name has ever been changed from the most recent time you held an active license in Virginia or were licensed in other jurisdictions or other than what is listed on your application. Photocopies of marriage licenses or court orders are accepted.

_____ 9. Please be aware that your signed and notarized application affidavit authorizes the release of confidential information, affirms that your application is complete and correct, and attests that you have read and understand and will remain current with the laws and regulations governing the practice of dentistry and dental assisting in Virginia.

PLEASE NOTE:

- If your Virginia Registration is not reinstated within six months of the Board's receipt of the application, certain portions of the application may need to be resubmitted before your application can be reviewed.
- You might obtain the Virginia laws and the regulations governing the practice of dental assistants at www.dhp.virginia.gov/dentistry.
- To receive notice that your application has been delivered to the Board, it is suggested that the complete packet be mailed by "Certified Mail-Return Receipt Requested" or with "Delivery Confirmation".
- Within approximately 10 business of receipt of an application, applicants will be notified of missing application items.
- Documents submitted with an application are the property of the board and cannot be returned.
- Consistent with Virginia law §54.1.2400.02 and mission of the Department of Health Professions, addresses of health professionals are made available to the public. Normally, the Address of Record is the publically disclosable address. If you do not want your Address of Record to be made public, state law allows you to provide a second, publically disclosable address. Typically, this other address is the work or practice address. If you would like for your Address of Record to be made available to the public, complete both sections with the same address.



Virginia Board of Dentistry
Virginia Department of Health Professions
9960 Mayland Drive, Suite 300
Henrico, VA 23233-1463
804-367-4538
www.dhp.virginia.gov/dentistry

APPLICATION FOR REINSTATEMENT OF DENTAL ASSISTANT II REGISTRATION

INSTRUCTIONS: Type or print clearly. Complete all sections. If the space provided for any answer is insufficient, complete your answer on a separate page, specify the number of the question to which it relates, sign the page and enclose it with the application.

I. GENERAL INFORMATION

| | | | |
|-------------------------------------|---------------------|--|------------------------------|
| Name: Last | First | Middle/Maiden | Suffix |
| Address of Record (Mailing Address) | City | State | Zip Code Telephone Number |
| Public Disclosable Address | City | State | Zip Code Telephone Number |
| Email Address: | | Fax Number: | |
| Date of Birth ____/____/____ | | Social Security Number or <u>Virginia</u> DMV Control Number ____-____-____ | |
| Virginia DAII Registration Number: | Date of Expiration: | Name at time of Original Licensure* | |

Reinstatement of Registration is sought for (check all that apply):

1. Performing pulp capping procedures
 2. Packing and carving of amalgam restorations;
 3. Placing and shaping composite resin restorations with a slow speed hand piece;
 4. Taking final impressions;
 5. Use of a non-epinephrine retraction cord;
 6. Final cementation of crowns and bridges after adjustment and fitting by the dentist.

Please check the applicable box below:

REINSTATEMENT REQUESTED DUE TO LAPSE OF REGISTRATION
 REINSTATEMENT REQUESTED DUE TO SUSPENSION
 REINSTATEMENT REQUESTED DUE TO REVOCATION

NOTE: In accordance with §54.1-116 of the *Code of Virginia*, you are required to submit your Social Security Number or your control number issued by the Virginia Department of Motor Vehicles. If you fail to do so, the processing of your application will be suspended and fees will not be refunded. This number will be used by the Department of Health Professions for identification and will not be disclosed for other purposes except as provided by law. Federal and state law requires this number be shared with other agencies for child support enforcement activities.

FOR OFFICE USE ONLY

| | | |
|------------|------------------|-----------------------|
| FEE AMOUNT | APPLICANT NUMBER | DATE OF REINSTATEMENT |
|------------|------------------|-----------------------|

3. APPLICANT HISTORY

ALL QUESTIONS MUST BE ANSWERED. If any of the following questions are answered "YES", explain and substantiate with documentation. Letters must be submitted by your attorney regarding malpractice suits. Letters must be submitted by any treating professionals regarding health treatment and shall include diagnosis, treatment and prognosis.

| b. | Has your practice since expiration of your Registration been in the Commonwealth of Virginia? If yes, give location. _____ | [] Yes | [] No | | | | | | | | | | | | | | | | |
|--------------|--|-------------|--------------|--------------|----------------|-------------|--------------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| c. | Has any of your work since the expiration of your DAll Registration been in any field other than the practice of dental assisting? If yes, give details, jurisdiction(s) and date(s). _____ _____ _____ | [] Yes | [] No | | | | | | | | | | | | | | | | |
| d. | Have you ever been denied a license/registration? If yes, give details, jurisdiction(s) and date(s) on a separate page. | [] Yes | [] No | | | | | | | | | | | | | | | | |
| e. | <p>List <u>all</u> licenses/registrations/certificates which you have been issued to practice as a dental assistant or as any other health care professional.</p> <table border="0" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: center; width: 25%;">Jurisdiction</th> <th style="text-align: center; width: 25%;">License Number</th> <th style="text-align: center; width: 25%;">Date Issued</th> <th style="text-align: center; width: 25%;">Date Expired</th> </tr> </thead> <tbody> <tr> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> <tr> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> <tr> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> </tbody> </table> | | | Jurisdiction | License Number | Date Issued | Date Expired | _____ | _____ | _____ | _____ | _____ | _____ | _____ | _____ | _____ | _____ | _____ | _____ |
| Jurisdiction | License Number | Date Issued | Date Expired | | | | | | | | | | | | | | | | |
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| _____ | _____ | _____ | _____ | | | | | | | | | | | | | | | | |
| _____ | _____ | _____ | _____ | | | | | | | | | | | | | | | | |
| f. | Have you ever been convicted of a violation of or pled Nolo Contender to any federal, state or local statute, regulation or ordinance, or entered into any plea bargaining relating to a felony or misdemeanor? (Excluding traffic violations, except convictions for driving under the influence.) If yes, you must provide an explanation and include an original copy of the disposition/record, certified by the Clerk of the Court, <u>unless</u> you provided this information on your previous application. | [] Yes | [] No | | | | | | | | | | | | | | | | |
| g. | Have you ever voluntarily surrendered your clinical privileges while under investigation, been censured or warned, or been requested to withdraw from the staff or any hospital, nursing home, other health care facility, or any health care provider? If yes, give details, jurisdiction(s) and date(s) on a separate page, <u>unless</u> you provided this information on your previous application. | [] Yes | [] No | | | | | | | | | | | | | | | | |
| h. | Have you ever been a defendant in a military court martial or received medical or other than honorable discharge? If yes, give details, jurisdiction(s) and date(s) on a separate page, <u>unless</u> you provided this information on your previous application. | [] Yes | [] No | | | | | | | | | | | | | | | | |
| i. | Have you, within the last two (2) years, been physically or emotionally dependent upon the use of alcohol/drugs or been treated by, consulted with or under the case of a professional for any substance abuse? If yes, give details, jurisdiction(s) and date(s) on a separate page, and provide a letter of explanation from the treating professional(s), including summary of diagnosis, treatment and prognosis, <u>unless</u> you provided this information on your previous application. | [] Yes | [] No | | | | | | | | | | | | | | | | |
| j. | Have you, within the last two (2) years, received treatment for, or been hospitalized for, a nervous, emotional or mental disorder? If yes, provide a letter of explanation from the treating professional(s), including summary of diagnosis, treatment and prognosis, <u>unless</u> you provided this information on your previous application. | [] Yes | [] No | | | | | | | | | | | | | | | | |
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| k. | Do you have a physical disability, disease, or diagnosis which could affect your performance of professional duties? If yes, give details, jurisdiction(s) and date(s) on a separate page, and provide a letter of explanation from the treating professional(s), including summary of diagnosis, treatment and prognosis, <u>unless</u> you provided this information on your last application. | [] Yes | [] No |
| l. | Have you ever been adjudged mentally incompetent, or been voluntarily or involuntarily committed to a mental institution? If yes, give details, jurisdiction(s) and dates) on a separate page, and provide certified copies of all applicable court documents, <u>unless</u> you provided this information on your previous application. | [] Yes | [] No |
| m. | Did you relocate with a spouse who is the subject of a military transfer to the Commonwealth of Virginia? | [] Yes | [] No |

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FORM C
CERTIFICATION OF AUTHORIZATION TO PERFORM EXPANDED DUTIES AS A DENTAL ASSISTANT

Please forward one form to each state dental board where you hold or have ever held registration as a dental assistant. Some states require a fee, paid in advance, for providing this information. To expedite, you may wish to contact the applicable state board(s). Form C may be photocopied if copies are needed.

I am making application for registration as a dental assistant II in Virginia:

I, _____, was granted License/registration Number _____ on _____ by the State of _____.
(DATE)

The Virginia Board of Dentistry requests that I submit evidence that my license/registration in the State of _____ is in good standing. You are hereby authorized to release any information in your files, favorable or otherwise directly to the Virginia Board of Dentistry. Your early attention is appreciated.

Applicants Signature

Date

Executive officer of State Board: Please complete and return this form to the applicant. If disciplinary action has been taken, return the form to the Board of Dentistry.

State of _____ Name of Licensee _____

License # _____ Issued _____

By Reciprocity Examination Endorsement with the State of _____

License Status and Expiration Date: _____

Please check all duties the licensee is currently authorized to perform:

- 1) Performing pulp capping procedures;
- 2) Packing and carving of amalgam restorations;
- 3) Placing and shaping composite resin restorations with a slow speed hand piece;
- 4) Taking final impressions;
- 5) Use of a non-epinephrine retraction cord;
- 6) Final cementation of crowns and bridges after adjustment and fitting by the dentist.

Has applicant's license ever been disciplined, suspended or revoked NO YES

If yes, give details and attach supporting documentation (Finding of Fact, Conclusions of Law, Orders): _____

SEAL

Signature

Title

Date