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

APPLICATION FOR A FACULTY LICENSE TO TEACH DENTISTRY

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

____ **1**.**Application:** Please be sure that all information and questions are completed on the application.

____ **2**.**Application Fee**: The fee for a **Faculty License to Teach Dentistry is $400** 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 18VAC60-21-40(G) all fees are non-refundable. Your application will not be reviewed until you have submitted payment.

____ **3**.**Form A – Original** certification of graduation by each dental school which granted you a dental degree or certificate from a dental program accredited by the Commission on Dental Accreditation of the American Dental Association (CODA), which consists of either a pre-doctoral dental education program or at least a 12-month post-doctoral advanced general dentistry program or a post-doctoral dental education program in any other specialty. Faxed copies are not acceptable. Applicants must submit a Form A for **each** degree and/or certificate earned from a dental program accredited by the Commission on Dental Accreditation of the American Dental Association. The school may use this form or its own form to meet this requirement. The certification must bear the school's seal or be on letterhead and must include the program's CODA accreditation status at the time you completed the program.

____ **4.**Final **original** transcript bearing SEAL, date degree received and registrar's signature for each CODA accredited dental program you have completed. Copies of transcripts, certificates and diplomas are not acceptable.

____ **5.Form B**. Chronology: List **ALL** activities since receiving your doctoral degree or certification. *(Resumes and curriculum vitas are not accepted as substitutes for completing the chronological listing and will not be considered.)*

____ **6.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 dentist or as another health care professional. Copies of permits are not accepted. Verification cannot be older than 6 months from date prepared.

Applicants who have not completed a CODA accredited dental program are required to hold a current, unrestricted license to practice dentistry in at least one other United States jurisdiction.

____ **7.Original**, current report, not older than 6 months from date prepared, must be obtained by Self Query from the National Practitioner Data Bank (NPDB), which may be requested through their website at www.npdb.hrsa.gov. There is a fee for this report. ***This report from NPDB is required from all applicants, without exception*** *(Regulation 18VAC60-21-190.3)***.**

____ **8**.An **original** grade card **indicating passage of parts I & II** issued by the Joint Commission on National Dental Examinations is required. Copies of grade cards are not 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 in Virginia.

____ **10.Name Change**: Documentation must be provided to show each name change(s) if your name has ever been changed from the time you attended school or were licensed in other jurisdictions or other than what is listed on your application. Photocopies of marriage licenses or court orders are accepted.

____ **11.Original** letter from the dean or program director of the dental program, on letterhead, verifying that the applicant is being hired by the program and including an assessment of the applicant's clinical competency and clinical experience that qualifies the applicant for a faculty license.

FYI

National Practitioner Data Bank
P.O. Box 10832
Chantilly, VA 20153
1-800-767-6732
www.npdb.hrsa.gov

National Board Scores
American Dental Association
Commission on Dental Accreditation
211 East Chicago Avenue
Chicago, IL 60611-2678
www.ada.org.en/jcnde/examinations/

Notes:

- An applicant for a Faculty License to Teach Dentistry must meet one of the following qualifications:

    1. Is a graduate of a dental school or college or the dental department of a college or university, hold a current unrestricted license to practice dentistry in at least one other United States Jurisdiction and have never been licensed to practice dentistry in the Commonwealth; **or**

    2. Is a graduate of a dental school or college or the dental department of a college or university, has completed an advanced dental education program accredited by the Commission on Dental Accreditation of the American Dental Association, and has never been licensed to practice dentistry in the Commonwealth.

- **The holder of a Faculty License to Teach Dentistry may practice intramurally and may receive fees for service but cannot practice privately.**

- **PLEASE NOTE**: If your Virginia License is not issued within six months of the Board's receipt of parts of the application, certain portions of the application may need to be resubmitted before your application can be reviewed.

- **DEA REGISTRATION**: Applicants must have a dental license prior to applying for a DEA License. Requests for an application in Virginia should be made to the following: Drug Enforcement Administration, P.O. Box 28083, Washington, DC 20038-8083; 1-800-882-9539; www.deadiversion.usdoj.gov.

- You might obtain the Virginia laws and regulations governing the practice of dentistry at www.dhp.virginia.gov/dentistry.

- To receive notice that your application and supporting documents have been delivered to the Board, it is suggested that the documents be mailed by "Certified Mail-Return Receipt Requested" or with "Delivery Confirmation".

- Within approximately 10 business days 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 licensees 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.

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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.

1. GENERAL INFORMATION

Name: Last	First	Middle/Maiden	Suffix

Address of record (Mailing Address)	City	State	Zip	Telephone Number
Public Disclosable Address	City	State	Zip	Telephone Number

Email Address	Fax#

Date of Birth	**Social Security Number or Virginia DMV control Number**
_____/_____/_____	____ ____ ____---____ ____--____ ____ ____ ____

DENTAL GRADUATION DATE	PROFESSIONAL DEGREE	DENTAL SCHOOL/CITY/STATE OR COUNTRY
____ ____ ____ Month Day Year		
ADVANCED PROGRAM GRADUATION DATE ____ ____ ____ Month Day Year	RESIDENCY/SPECIALTY	ADA-CODA APPROVED DENTAL SCHOOL/CITY/STATE

APPLICANTS DO NOT USE SPACES BELOW THIS LINE – FOR OFFICE USE ONLY

DATE RECEIVED	CHRONOLOGY	____NATIONAL PRACTITIONER DATA BANK	NATIONAL BOARD

TRANSCRIPT	CERTIFICATION (EDUCATION) (FORM A)	CERTIFICATION (LICENSE FROM OTHER STATES (Form C or Letter)

FEE	APPLICANT #	LICENSE #	DATE ISSUED	VERIFY NEVER LICENSED IN VIRGINIA

***Name change: Documentation must be provided to show name change(s) if name has ever been changed from the time you attended school or while you were licensed in other jurisdictions.**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 that this number be shared with other agencies for child support enforcement activities.**

2. ALL EXAMINATIONS **Please answer <u>all</u> "exam" questions "a" through "g"**

a. Southern Regional Testing Agency (SRTA) – Exam Site _____ _____/____/_____
[ ] Passed [ ] Failed [ ] Never Taken [ ] Taken more than once (attach explanation) Month/Day/Year

b. Western Regional Examining Board (WREB) – Exam Site _____ _____/____/_____
[ ] Passed [ ] Failed [ ] Never Taken [ ] Taken more than once (attach explanation) Month/Day/Year

c. North East Regional Board (NERB/CDCA) – Exam Site _____ _____/____/_____
[ ] Passed [ ] Failed [ ] Never Taken [ ] Taken more than once (attach explanation) Month/Day/Year

d. Central Regional Dental Testing Services, Inc. (CRDTS) –Exam Site_____ _____/____/_____
[ ] Passed [ ] Failed [ ] Never Taken [ ] Taken more than once (attach explanation) Month/Date/Year

e. Council of Interstate Testing Agencies, Inc. (CITA) – Exam Site_____ ____/____/_____
[ ] Passed [ ] Failed [ ] Never Taken [ ] Taken more than once (attach explanation) Month/Date/Year

f. State of _____ –Exam Site_____ _____/____/_____
[ ] Passed [ ] Failed [ ] Never Taken [ ] Taken more than once (attach explanation) Month/Date/Year

g. ADEX _____-Exam Site_____ _____/___/_____
[ ] Passed [ ] Failed [ ] Never taken [ ] Taken more than once (attach explanation)

g. National Board Examination: (Original grade cards are required) _____/____/_____
[ ] Passed [ ] Failed [ ] Never Taken [ ] Taken more than once (attach explanation) Month/Day/Year

The Board must receive an <u>original</u> score card or report from the testing agency for each examination reported above.

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.

a. List in chronological order including months and years, the dental school(s) attended:
(include specialty and advanced programs)

Months & Years	Name of Dental School	Passed/Failed
_____ to _____	_____	_____
_____ to _____	_____	_____
_____ to _____	_____	_____

b. List all jurisdictions in which you currently hold or have ever held a license/registration/certification to practice as a dentist or as another health care professional.

Jurisdiction	License Number	Date Issued	Expiration Date
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

c. Have you ever been dropped, suspended, expelled, or disciplined by any school or college for any cause whatever? If yes, give details, schools(s), address(es) and date(s) on a separate page. [ ] Yes [ ] No

d. Have you ever been denied a license, or the privilege of taking a dental licensure/competency examination by a licensing authority? If yes, give detail(s), jurisdiction(s) and date(s). [ ] Yes [ ] No

_____

_____

e. Have you ever failed a dental licensing examination(s)? [ ] Yes [ ] No
If yes, give details, jurisdiction(s) and date(s)._____

_____

f. Have you ever been convicted of a violation or plead Nolo Contedere, to any federal, state or local statute, regulations 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, give details, jurisdiction(s) and date(s) on a separate page, and include a copy of the disposition/record certified by the Clerk of the Court. [ ] 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 of any hospital, nursing home other health care facility, or any health care provider? If yes, give details, jurisdictions(s) and date(s) on a separate page. [ ] Yes [ ] No

h. Have you ever had any of the following disciplinary actions taken against your license to practice dentistry, your DEA permit, Medicare, Medicaid, or are any such actions pending: suspension/revocations, or probations, or reprimand/cease and desist, or monitoring of practice, or limitation placed on scheduled drugs? If yes, give details, jurisdiction(s) and date(s) on a separate page. [ ] Yes [ ] No

i. Have you ever had any membership in a professional society revoked, suspended or sanctioned in any manner? If yes, give details, jurisdiction(s) and date(s) on a separate page. [ ] Yes [ ] No

j. 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. [ ] Yes [ ] No

k. Have you ever had any malpractice claims brought against you? If yes, give outcome, details, jurisdiction and dates for each claim on a separate page, and provide a letter from your attorney explaining each case. [ ] Yes [ ] No

l. 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 care 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 a summary of diagnosis, treatment and prognosis. [ ] Yes [ ] No

m. Have you, within the last two (2) years, received treatment for, or been hospitalized for a nervous, emotional or mental disorder? 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 a summary of diagnosis, treatment and prognosis. [ ] Yes [ ] No

n. Do you have a physical disability, disease, or diagnosis which could affect your performance or professional duties? If yes, provide a letter of explanation from the treating professional(s), including a summary of diagnosis, treatment, and prognosis. [ ] Yes [ ] No

o. Have you been adjudged mentally incompetent, or been voluntarily or involuntarily committed to a mental institution within the last five (5) years? If yes, give details, jurisdiction(s) and date(s) on a separate page, and provide certified copies of all applicable court documents. [ ] Yes [ ] No

p. Did you relocate with a spouse who is the subject of a military transfer to the Commonwealth of Virginia? [ ] Yes [ ] No

VIRGINIA BOARD OF DENTISTRY
APPLICATION AFFIDAVIT
(MUST BE COMPLETED BEFORE A NOTARY PUBLIC)

I, _____, being first duly sworn, depose and say that I am the person referred to in the foregoing application and supporting documents.

I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past and present) business and professional associates (past and present) and all governmental agencies and instrumentalities (local, state, federal or foreign) to release to the Virginia Board of Dentistry any information, files or records requested by the Board which is material to me and my application.

I have carefully read the questions in the foregoing application and have answered them completely, without reservations of any kind, and I declare under penalty of perjury that my answers and all statements made by me in the application and supporting documents are true and correct. Should I furnish any false information in this application, I hereby agree that such act shall constitute cause for the denial, suspension, or revocation of my license to practice in the Commonwealth of Virginia.

I have carefully read the laws and regulations related to the practice of dentistry and dental hygiene. I hereby agree to abide by and remain current with the applicable laws and regulations which are available on www.dhp.virginia.gov, and

I have attached a certified check, cashier's check or money order in the amount of $_____ made payable to the **Treasurer of Virginia**. I fully understand that funds submitted as part of the application shall not be refunded.

_____
Signature of Applicant

State of _____

County/City of _____

Sworn and subscribed to, before me, this _____day of _____, _____.
Day Month Year

My commission expires on _____.

_____
Signature of Notary Public

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DENTAL FACULTY FORM A
CERTIFICATION OF DENTAL SCHOOL

APPLICANT: ENTER YOUR NAME AND GRADUATION DATE BELOW THEN SEND THIS FORM TO THE DEAN OR DIRECTOR OF EACH DENTAL SCHOOL WHICH GRANTED YOU A DEGREE OR CERTIFICATE.

APPLICANT _____ GRADUATION DATE:_____

DEAN/PROGRAM DIRECTOR: Please provide certification that the applicant named above received a dental degree or certificate from your dental school or dental program at a college or university. This certification may be provided by completing this form or by providing a letter with all the information requested on this form. Either document must bear the school's seal or be on letterhead. Certification made prior to the applicant's graduation cannot be accepted.

NAME OF SCHOOL: _____

NAME OF PROGRAM: _____

DEGREE or CERTIFICATION GRANTED:_____

DATE GRANTED: _____/_____/_____
Month Day Year

Was this dental education program accredited by the Commission on Dental Accreditation of the ADA (CODA)? _____YES _____ NO

By affixing my signature below, I certify that the applicant named above is a graduate and a holder of a diploma or a certificate from a dental school or dental program at a college or university.

_____
Signature

SEAL

_____
Title

_____
Date

Commonwealth of Virginia
Board of Dentistry

FORM B: CHRONOLOGY

NAME OF APPLICANT:_____

Every applicant must provide a complete chronological, personal and professional history of all activities you have engaged in since receiving your degree or certification, including teaching positions, all periods of non-professional activity or employment, volunteer work and all periods of unemployment. **Curriculum vita and resumes are not accepted as substitutes for completing the chronological listing and will not be considered.**

Form B may be photocopied if additional space is needed.

FROM Month/Year	**TO** Month/Year	**POSITION/ACTIVITY**	**Employer/Contact Person for practice verification and the person's Complete Address, and Telephone #**

COMMONWEALTH OF VIRGINIA

BOARD OF DENTISTRY

Department of Health Professions

9960 Mayland Drive, Suite 300
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FORM C

CERTIFICATION OF DENTAL LICENSURE

Please forward one form to each state dental/dental hygiene board where you hold or have ever held a dental/dental hygiene license. 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 licensure in Virginia for a Faculty License to Teach Dentistry:

I, was granted License Number _____, on _____ by the State of
Month Date Year.
_____. The Virginia Board of Dentistry requests that I submit evidence that my license 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.

_____ _____ _____
Applicant's Signature Applicant's Typed/Printed Name Applicant's Address

_____

Executive officer of State Board: If no disciplinary action has been taken, please complete and return this form to the applicant. If disciplinary action has been taken, please send the form directly to the Virginia Board of Dentistry.

State of _____ Name of Licensee_____

Graduate of_____ License #_____ Issued_____

By [ ] Reciprocity [ ] Examination* [ ] Endorsement with the State of _____

License is: [ ] Current-Expires_____ [ ] Active [ ] Inactive [ ] Lapsed-Expired_____

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):_____

_____

Comments, if any _____

_____
Signature

SEAL

_____
Date

_____
Title

*** If licensed by a state administered examination, please provide a score card or report which shows that testing included live patients.**