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

Application Instructions for Restricted Volunteer Dental License

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 then destroyed.

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

____ 2.**Application** Fee: The fee for a Restricted Volunteer Dental license is $25 and must be paid with a **certified check, cashier's check or money order**, made payable to The Treasurer of Virginia. Your application will not be reviewed or considered until you have submitted payment. Pursuant to 18VAC60-21-40(G) Regulations Governing the Practice of Dentistry, fees are nonrefundable.

____ 3.**Form AA**: If applicable, certification must be provided by the supervising dentist indicating he/she will review the quality of care rendered by the dentist with the restricted volunteer license at least every thirty days pursuant to 18VAC60-21-230.D(3)).

____ 4.**Form B**: List **ALL** activities since receiving your doctoral or dental hygiene degree or certification. *(Resumes and curriculum vitas are not accepted as substitutes for completing the chronological listing and will not be considered.)* **Applicants must have had at least 5 years of clinical practice in Virginia; another jurisdiction of the United States or federal civil or military service.**

____ 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 dentist, dental hygienist or as any other health care professional. Copies of permits are not accepted. Verification cannot be older than 6 months from date prepared. **Applicants must have held an unrestricted dental license in Virginia or another state, as a licensee in good standing at the time the license expired or became inactive.**

____ 6.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. In addition, it verifies that no remuneration will be received directly or indirectly for dental or dental hygiene services.

____ 7.**Name Change:** Documentation must be provided to show each name change 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.

_____ 8.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)****.***

NOTES:

- **A person holding a restricted volunteer dental license shall only practice in public health or community free clinic that provides dental services to populations of undeserved people and only treat patients who have been screened by the approved clinic and are eligible for treatment.**

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

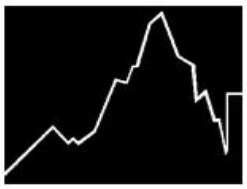
- To receive notice that your supporting documents have been delivered to the board, it is suggested that the documents be mailed by "Certified Mail-Return Receipt Requested" or with "Delivery Confirmation".

- 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.

- **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.

- 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.



Commonwealth of Virginia
Board of Dentistry
Department of Health Professions
9960 Mayland Drive, Suite 300
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804-367-4538
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APPLICATION FOR RESTRICTED VOLUNTEER DENTAL LICENSE

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/Dental Hygiene Graduation Date	Degree or Certificate	ADA-Coda Approved Dental School	City/State
_____ _____ _____ Month Date Year			

FOR OFFICE USE ONLY

Date Received	Form AA	Form B	Form C –Certification of Licensure

_____National Practitioner Data Bank	

Fee	APPLICANT #	LICENSE #	DATE ISSUED

***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.**

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) attended: (include specialty and advanced programs)

Months & Years	Name of Dental School (ADA-CODA)	Passed/Failed
_____ to _____	_____	_____
_____ to _____	_____	_____
_____ to _____	_____	_____

b. List all jurisdictions in which you have ever held a license/registrations/certification to practice dentistry or as any other 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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FORM AA

INSTRUCTIONS: You may be required now or will be required in the future to have a sponsoring dentist in order to hold a restricted volunteer license. You must have a sponsor if you have not been in active practice within the past five years of making application.

NAME OF APPLICANT: _____Dental Restricted Volunteer License

1. Name and address of clinic you will be volunteering at:
   _____

   _____

2. Are you still in active practice: Yes _____ No _____

3. If you answered no above, please give the month and year when you were last in active practice. Month _____ Year _____

4. How many years have passed since your last date of service: _____

5. **a**. If your answer above is less than five years, you do not presently need a sponsor and you may stop here. The date when you must have a sponsor will be specified on your restricted volunteer license. It is your responsibility to obtain and report your sponsor by the date specified on your license. You may voluntarily obtain and report a sponsor with your application.

   b. If your answer above is five years or greater then your sponsor must provide the information requested below.

TO BE COMPLETED BY SPONSOR:

By affixing my signature below, I verify that I will review the quality of care rendered by the above named applicant at least every 30 days who will only treat patients who have been screened by the approved clinic and are eligible for treatment. I will directly observe patient care being provided and review all patient charts at least quarterly. Such supervision shall be noted in patient charts and maintained in accordance with 18VAC60-21-90 as required by 18VAC60-21-230.D(3)

_____
Signature of Sponsor

_____
Virginia License Number

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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 Name or Practice Contact and Complete Address & Telephone Number**

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BOARD OF DENTISTRY

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FORM C
CERTIFICATION OF DENTAL BOARDS

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 by: Dental Restricted Volunteer License

I, _____, was granted License Number _____

on _____ by the State of _____. The Virginia Board of Dentistry
Month Date Year

requests that I submit evidence that my license 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.

_____ _____ _____
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 [ ] If licensed by state clinical exam, provide year and check her if exam included treatment of live patient _____ [ ] 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):_____

_____

Derogatory information, if any:_____

Comments, if any:_____

SEAL _____ _____ _____
Signature Title Date