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

INSTRUCTIONS FOR A TEMPORARY RESIDENT'S 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.

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

_____ **2**.**Application Fee**: The fee for a **Temporary Resident's License is $60** 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 B** - Recommendation from the dean of the dental school or the director of the accredited advanced dental education program specifying the applicant's acceptance as an intern, resident or post-doctoral certificate or degree candidate. The beginning and ending dates of the internship, residency or post-doctoral program must be specified.

_____ **4.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. Verifications cannot be older than 6 months from date prepared

_____ **5**.**Form D:** 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.**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.

_____ **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**.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.

_____ **9**.**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.

FYI

National Practitioner Data Bank (NPDB)
P.O.Box 10832
Chantilly, VA 20153-0832
1-800-767-1964
703-802-4109 FAX
www.npdb.hrsa.gov

National Boards
American Dental Association
Joint Commission on Dental Examiners.
211 East Chicago Ave.
Chicago, IL 60611-2678.
1-800-232-1694
www.ada.org

NOTES:

- **The temporary license permits the holder to practice only in the hospital or outpatient clinics that are recognized parts of an advanced dental education program. The temporary license holder is prohibited from practicing outside of the advanced dental education program.**

- You might obtain the Virginia laws and the regulations governing the practice of dentistry 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".

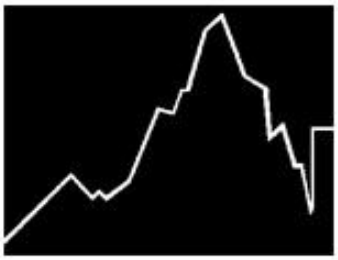
- Within approximately 10 business days of receipt of an application, applicants will be notified of missing application items. Review of completed applications for licensure by credentials may take another 5 to 20 business days.

- Documents submitted with an application are the property of the board and cannot be returned.

- A Virginia address must be provided before a Temporary Resident's License can be issued.

- 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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APPLICATION FOR TEMPORARY RESIDENT'S 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.

I. General Information

Name: Last	First	Middle/Maiden	Suffix

Address of Record (Mailing Address)	City	State	Zip Code	Telephone Number
Publicly Disclosable Address	**City**	**State**	**Zip Code**	**Telephone Number**

Email Address	Fax #

Date of Birth	Social Security Number or Virginia DMV Control Number
___ ____/___ ___/___ ___ ___ ___	___ ___ ___---___ ___ ---___ ___ ___ ___

DDS/DMD Graduation Date	Professional Degree	ADA-CODA APPROVED DENTAL SCHOOL/CITY/STATE
____ ____ ____ Month Day Year		

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

Date Received	Chronology (Form D)	____National Practitioner Data Bank	National Boards

FEE	APPLICANT #	LICENSE #	DATE ISSUED

Transcript	Recommendation from dean/director (Form B)	Certification (License from other states(Form C or Letter)

***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.**

II. 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 _____	_____	_____
_____ 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
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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 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

f. 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

g. 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

h. 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

i. 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

j. Have you ever had any malpractice suits brought against you in the last ten (10) years? If yes, give details, jurisdiction(s) and date(s) for each suit on a separate page, and provide a letter from your attorney explaining each case. [ ] Yes [ ] No

k. 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

l. 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

m. 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

n. 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

o. 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 B

MEMORANDUM:

TO: Virginia Board of Dentistry

FROM: Dean of dental school or the director of the accredited graduate program

Name of Training Institute: _____

Complete Mailing address: _____

_____

Telephone: _____

This is to certify that _____ will be enrolled in _____
Name of resident Name of Program

at _____, _____
Name of dental school Street Address

_____
City, State and Zip Code

From _____ with an expected completion of date of _____
(Month/Day/Year) (Month/Day/Year)

Dr. _____ is a graduate of _____
Name of resident Dental School

_____
Signature

_____
Title

_____
Date

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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 a Temporary Resident's License:

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):_____

_____

Derogatory information, if any:_____

Comments, if any:_____

_____ _____ _____
Signature Title Date

SEAL

COMMONWEALTH OF VIRGINIA

BOARD OF DENTISTRY

FORM D: 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 #**