

**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](http://www.dhp.virginia.gov/dentistry)**

**REQUIREMENTS AND INSTRUCTIONS FOR A TEMPORARY RESIDENT'S LICENSE TO PERSONS ENROLLED IN ADVANCED DENTAL EDUCATION PROGRAMS**

A dental intern, resident or post-doctoral certificate or degree candidate applying for a temporary resident's license to practice in Virginia shall have successfully complete a D.D.S. or D.M.D. dental degree program required for admission to board-approved examinations.

**All** of the following must accompany the enclosed application for licensure. An incomplete application and or fees could result in the delay of the processing or return of your application. Pursuant to Regulation 18 VAC 60-20-40, all fees are non-refundable.

- \_\_\_\_\_ **1. Licensure application.**
- \_\_\_\_\_ **2. Application Fee \$60.** Certified check, cashier's check or money order made payable to the Treasurer of Virginia
- \_\_\_\_\_ **3.. Form A –** Certification of graduation by dental school which granted you a dental degree from a dental program accredited by the Commission on Accreditation of the American Dental Association of confirmation from the registrar of the school or college conferring the professional degree **OR** official transcript confirming the professional degree and date the degree was received.
- \_\_\_\_\_ **4.** Submit a recommendation (**Form B**) from the dean of the dental school or the director of the accredited graduate program specifying the applicant is acceptance as an intern, resident or post-doctoral certificate or degree candidate in an advanced dental education program. The beginning and ending dates of the internship, residency or post-doctoral program shall be specified.
- \_\_\_\_\_ **5. Form C-** (if applicable) Licensure verification from any jurisdiction in which you hold or have ever held a license to practice dentistry, copies of licensure permits are not accepted. Verification cannot be older than 6 months.
- \_\_\_\_\_ **6. Form D** (if applicable) - Chronology, follow instructions on form
- \_\_\_\_\_ **7. Original** grade card issued by the Joint Commission on National Dental Examinations. Original grade cards submitted by the applicant are accepted. Copies of grade cards are not accepted;
- \_\_\_\_\_ **8. Current** reports, not older than 6 months, from the (1) Healthcare integrity and Protection Data Bank (HIPDB and (2) National practitioner Data Bank (NPDB) National Practitioner Data Bank and Healthcare Integrity and Protection Data Bank.
- \_\_\_\_\_ **9. Application Affidavit** which must be notarized and which 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 applicable Virginia dental and dental hygiene laws and regulations of the Virginia Board of Dentistry. A passport-type photo not older than 6 months is required.

\_\_\_\_\_ **10. 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.

The temporary license applies only to practice in the hospital or outpatient clinics of the hospital or dental school where the internship, residency or post-doctoral time is served. Outpatient clinics in a hospital or other facility must be a recognized part of an advanced dental education program.

The temporary license holder shall be responsible and accountable at all times to a licensed dentist, who is a member of the staff where the internship, residency or post-doctoral candidacy is served. The temporary licensee is prohibited from employment outside of the advanced dental education program where a full license is required.

The temporary license holder shall abide by the accrediting requirements for an advanced dental education program as approved by the Commission on Dental Accreditation of the American Dental Association.

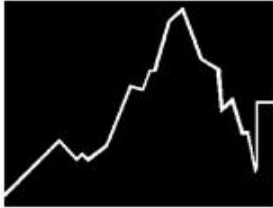
#### **FYI**

National Practitioner Data Bank (NPDB)  
Healthcare Integrity and Protection Bank (HIPBD)  
P.O. Box 10832  
Chantilly, VA 20153-0832  
1-800-767-6732  
703-802-4109 FAX  
[www.npdb-hipdb.hrsa.com](http://www.npdb-hipdb.hrsa.com)

National Boards  
American Dental Assoc.  
Joint commission on Dental Examiners.  
211 East Chicago Ave.  
Chicago, IL 60611-2678.  
312-44-2500  
312-440-1915 FAX  
[www.ada.org](http://www.ada.org)

#### **NOTES:**

- **Consistent with Virginia law §54.1.2400.02 and the 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.**
- **You might obtain the Virginia dental and dental hygiene laws and the regulations of the Virginia Board of Dentistry on-line at [www.dhp.virginia.gov/dentistry](http://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”.**
- **After 10 business days of applying, you might check on-line to see if your license has been issued by going to [www.dhp.virginia.gov](http://www.dhp.virginia.gov) and selecting License Lookup.**
- **Applicants who submit an incomplete application will be notified within 10 business days of receipt that required information is missing.**
- **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.**



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 Board of Virginia  
 Department of Health Professions  
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## APPLICATION FOR TEMPORARY RESIDENT'S LICENSE

**INSTRUCTIONS:** Use typewriter or print clearly. If the space provided for any answer is insufficient, the applicant must complete his/her answer on a separate page, signed by him/her, specifying the number of the question to which it relates and enclose the page with this application. **OMISSIONS OR INACCURACIES ARE GROUNDS FOR REJECTION.**

### I. APPLICANT PROFILE: PLEASE COMPLETE ALL SECTIONS (PRINT OR TYPE)

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 ____-____-____	
Graduation Date ____/____/____ Month Day Year	Professional Degree	ADA Approved Dental School	City State

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

Date Received	Chronology (Form B)	<input type="checkbox"/> Healthcare Integrity and Protection Bank <input type="checkbox"/> National Practitioner Data Bank	National Boards
FEE	APPLICANT #	LICENSE #	DATE ISSUED
Transcript	Certification (Education) Form A	Recommendation from dean/director (Form B)	Certification (License from other states) (Form C or Letter)

\*Name change: Documentation must be provided to show name changes(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 for by law. Federal and state law requires that this number be shared with other agencies for child support enforcement activities.

### III. 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. I hereby certify that I studied dentistry and received the degree or certificate of:

\_\_\_\_\_ on \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ from \_\_\_\_\_  
D.D.S. or D.M.D.                      Month    Day    Year    School/Program

List in chronological order including months and years, the dental school(s) attended:

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

b. List all jurisdictions in which you have been issued a license to practice dentistry, active or inactive.

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 failed the dental licensing examination(s) given for another jurisdiction? If yes, give details, jurisdiction(s) and date(s).  Yes  No
- \_\_\_\_\_
- \_\_\_\_\_
- 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 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
- 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

**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](http://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

SECURELY PASTE A PASSPORT-TYPE PHOTOGRAPH  
IN THE BOX BELOW. NOTARY SEAL MUST OVERLAY THE PHOTOGRAPH.

NOTARY SEAL  
MUST OVERLAY  
PHOTOGRAPH

**FORM A**  
**Temporary Resident's License**

**COMMONWEALTH OF VIRGINIA**  
**BOARD OF DENTISTRY**  
Department of Health Professions  
9960 Mayland Drive, Suite 300  
Henrico, VA 23233-1463  
(804) 367-4538 [www.dhp.virginia.gov/dentistry](http://www.dhp.virginia.gov/dentistry)

**CERTIFICATION OF DENTAL SCHOOL FOR TEMPORARY RESIDENT'S LICENSE**

APPLICANT: ENTER YOUR NAME AND GRADUATION DATE BELOW THEN SEND THIS FORM TO THE DEAN OR DIRECTOR OF EACH DENTAL/DENTAL HYGIENE 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/dental hygiene degree or certificate from your program and certification that the program completed was accredited by the Commission on Dental Accreditation of the ADA (CODA). The certification may be provided by completing this form or by providing a letter with the information requested on this form. Either document must bear the school's seal. The certification should be returned to the APPLICANT. Certifications made prior to the applicant's graduation cannot be accepted.

NAME OF SCHOOL: \_\_\_\_\_

NAME OF PROGRAM: \_\_\_\_\_

PROGRAM'S CODA ACCREDITATION STATUS: \_\_\_\_\_

DEGREE or CERTIFICATION GRANTED: \_\_\_\_\_

DATE GRANTED: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Month Day Year

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 CODA accredited dental program.

\_\_\_\_\_  
Signature

**(SEAL REQUIRED)**

\_\_\_\_\_  
Title

\_\_\_\_\_  
Date

**DEAN/REGISTRAR:** Please provide the applicant an original, final transcript of this alumni record, to include courses, grades, degree or certificate received, and date the degree or certificate was conferred, which bears the certified signature of the registrar and has the college seal affixed.

**Form B**  
**Temporary Resident's License**

**COMMONWEALTH OF VIRGINIA**  
**BOARD OF DENTISTRY**  
Department of Health Professions  
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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 Specialty

At \_\_\_\_\_, \_\_\_\_\_  
Name of training facility 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

\_\_\_\_\_  
Dean/Director

\_\_\_\_\_  
Signature



**Form C**

**Temporary Resident's License**

**COMMONWEALTH OF VIRGINIA**

**BOARD OF DENTISTRY**

Department of Health Professions

9960 Mayland Drive, Suite 300

Henrico, VA 23233-1463

(804) 367-4538 [www.dhp.virginia.gov/dentistry](http://www.dhp.virginia.gov/dentistry)

**CERTIFICATION OF DENTAL LICENSURE**

Please forward one form to each state dental/dental hygiene board where you hold or have ever held a dental 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 Residents License**

I, \_\_\_\_\_, was granted License Number \_\_\_\_\_  
on \_\_\_\_\_ 19\_\_\_\_ 20\_\_\_\_ by the State of \_\_\_\_\_. The Virginia Board of Dentistry  
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: 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 \_\_\_\_\_

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: \_\_\_\_\_

**SEAL**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Title

\_\_\_\_\_  
Date

**FORM D**  
**Temporary Resident's License**

**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, include teaching positions, internship, hospital affiliations, all periods of non-professional activity or employment, volunteer work, and all periods of unemployment.

Only applicants for dental **licensure by credentials** are required to provide the Number of Hours of Clinical Practice. You must report the number of hours you were engaged in clinical practice for each dental position you held within the six year period prior to submitting this application. Report multiple year positions as hours per year.

*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 #	Number of Hours of Clinical Practice