

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 REQUIREMENTS FOR
TEACHERS LICENSE (Code 54.1-2713) or
FULL-TIME FACULTY LICENSE (Code 54.1-2714.1)
Regulation 18VAC60-20-90

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.** (4 Pages) Please be sure that all information and questions are completed on the application. The application can be used for one year from date of receipt. Please note that a passport photo (full face) not older than six months is required and must be attached to Page 4 of the application. Additional photos are not required.
- _____ **2. Application Fee:** Certified check, cashier's check or money order, made payable to the **Treasurer of Virginia** in the amount of \$400 for applicants applying for a license to teach dentistry or a full-time faculty license. The fee can be used for one year from date of receipt. Pursuant to 18 VAC 60-20-40, all fees are non-refundable. A processing fee of \$35 will be charged for any check or money order returned unpaid by your bank.
- _____ **3. Form A – Original** certification of graduation from a dental program accredited by the Commission on Dental Accreditation of the American Dental Association, 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. 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. This information is only accepted from programs accredited by the Commission on Dental Accreditation of the American Dental Association. Documentation from foreign schools is not required. (Faxed copies are not acceptable)
- _____ **4. Final original** transcript bearing SEAL, date degree received and registrar's signature. Copies of transcripts, certificates and diplomas are not acceptable. A transcript or program verification is required for residency/advanced specialty programs. (Documentation from foreign schools is not required as foreign schools are not acceptable)
- _____ **5. Form B.** Chronology listing **ALL** activities since receiving doctoral degree. (Resumes and curriculum vitas are not required and are not accepted as substitutes for Form B.)

- _____ **6. Form C. Original** licensure verification from any jurisdiction in which you currently hold or have ever held a license to practice dentistry. Copies of licensure permits are not accepted. Verifications cannot be older than 6 months from date prepared.
- _____ **7. Original**, current reports, not older than 6 months from date prepared, obtained by self query to the **(1) Healthcare Integrity and Protection Data Bank (HIPDB) AND (2) National Practitioner Data Bank (NPDB). These two reports(which are combined as one report) are required from all applicants (Regulation 18 VAC 60-20-100) and should be submitted with the application.**
- _____ **8. An original grade card giving scores** issued by the Joint Commission on National Dental Examinations. An original grade card received from the Commission or from the applicant will be kept for one year. Copies of grade cards are not accepted.
- _____ **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 the regulations of the Virginia Board of Dentistry.
- _____ **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 of the dental school, on letterhead, noting where the applicant is employed or is to be employed indicating the applicant's employment status.

FYI

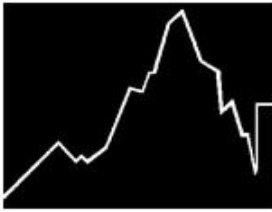
Healthcare Integrity and
Protection Data Bank
National Practitioner
Data Bank
P.O. Box 10832
Chantilly, VA 20153-0832
1-800-767-6732
www.npdb-hipdb.hrsa.gov

National Board Scores
American Dental Assoc.
Comm. On Dental Accred.
211 East Chicago Ave.
Chicago, IL 60611-2678
1-800-232-1694
www.ada.org

Approved Programs
American Dental Assoc.
Comm. On Dental Accred.
211 East Chicago Ave.
Chicago, IL 60611-2678
312-44--2500
www.ada.org

Notes:

- **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 updated/resubmitted before a license can be issued.
- **DEA REGISTRATION:** Applicants must have a dental license prior to applying for a DEA License. Requests for 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 dental and dental hygiene laws and the regulations of the Virginia Board of Dentistry on-line at www.dhp.virginia.gov/dentistry.
- **A jurisprudence examination is not required to complete an application; however it is recommended that applicants take the Virginia Dental Law examination to evaluate their understanding of the applicable laws and regulations governing the practice of dentistry and dental hygiene in the Commonwealth of Virginia before signing the APPLICATION AFFIDAVIT.** Enclosed is a "Candidate Information Bulletin" which gives you information on how to take the examination. However, if you obtained the application from the Board of Dentistry website, please go to "Forms, Applications and Exam Information" for a copy of the "Candidate information Bulletin".
- 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 days of receipt of application, applicants will be notified of missing application items.
- After 10 business days of applying, you might check online to see if your license has been issued by going to www.dhp.virginia.gov and selecting "License Lookup"
- 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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 Virginia Department of Health Professions
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APPLICATION FOR LICENSE TO PRACTICE DENTISTRY

Check the box that applies:

FULL-TIME FACULTY LICENSE

TEACHER'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.

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#	
Print Name as you wish it to appear on your license		Place of Birth	
Date of Birth ____/____/____		Social Security Number or Virginia DMV control Number ____-____-____	
DDS/DMD GRADUATION DATE ____/____/____ Month Day Year	PROFESSIONAL DEGREE	ADA-CODA APPROVED DENTAL SCHOOL/CITY/STATE	
ADVANCED PROGRAM GRADUATION DATE ____/____/____ Month Day Year	RESIDENCY/SPECIALTY DEGREE or CERTIFICATE	ADA-CODA APPROVED DENTAL SCHOOL/CITY/STATE	
APPLICANTS DO NOT USE SPACES BELOW THIS LINE – FOR OFFICE USE ONLY			
DATE RECEIVED	CHRONOLOGY (FORM B)	____ NATIONAL PRACTITIONER DATA BANK ____ HEALTHCARE INTEGRITY AND PROTECTION DATA BANK	NATIONAL BOARD
TRANSCRIPT	CERTIFICATION (EDUCATION) (FORM A)	CERTIFICATION (LICENSE FROM OTHER STATES FORM C OR LETTER)	
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.

2. ALL EXAMINATIONS

Please answer all "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) – 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. National Board Examination: (Original grade cards are required)
 Passed Failed Never Taken Taken more than once (attach explanation) _____/____/____
 Month/Day/Year

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 (ADA-CODA)	Passed/Failed
_____ 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	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

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FORM A
CERTIFICATION OF DENTAL/DENTAL HYGIENE SCHOOL

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.

(SEAL)

Signature

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.

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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, 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 calendar year, i.e. 600 hours in 2004 or 1000 hours each year for 2001 - 2004.

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 Per Year

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FORM C

CERTIFICATION OF DENTAL/DENTAL HYGIENE 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:

- [] Examination for Dental License
[] Examination for Dental Hygiene License
[] Reinstatement
[] Full Time Faculty
[] Credentials for Dental License
[] Endorsement for Dental Hygiene License
[] Teachers License
[] Registration for Volunteer Practice

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: _____

SEAL Signature Title Date

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