

### 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

### APPLICATION FOR CERTIFICATION TO PERFORM COSMETIC PROCEDURES

ТО	PE	RFORM COSM	METIC	PROCEL	DURES		
INSTRUCTIONS: Use typewriter or print separate page, signed by him/her, specifyir INACCURACIES ARE GROUNDS FOR RE	ng the n	umber of the question to	or any answe which it rela	er is insufficient ates and enclos	, the applicant mus e the page with thi	st complete is applicatio	his/her answer on a n. OMISSIONS OR
Name: Last	First	irst		Middle/Maiden			Suffix
Address of Record (Mailing Address)		City		State	Zip Code	Telepho	ne Number
Public disclosable Address		City		State	Zip Code	Telepho	ne Number
Email Address			Fax#				
Date of Birth			Social Security Number or Virginia DMV Control Number				
Virginia Dental License Number:		Virginia C	oral and Maxillo	facial Surgical Prac	ctice Registr	ation Number:	
Name of Practice (if applicable):			I				
Check only one and attach copy of docume			ral and Maxil	0,	<i>r</i> :		
Hospital privileges for Oral and Maxillofacia	al surge	ry are current at:					
Certification is sought for (check all that app	oly): F	ill out a procedure form a	and attach do	ocumentation fo	r each certification	you check.	
A. [ ] Rhinoplasty/similar procedures			E. [	] Browlift/ei	ther open or end	loscopic te	chnique/similar
<ul><li>B. [ ] Blepharoplasty/similar procedures</li><li>C. [ ] Rhytidectomy/similar procedures</li><li>D. [ ] Submental liposuction/similar procedures</li></ul>				] Laser resu	similar procedur /similar procedur /similar plication /similar plication	abrasion/si	milar procedures ocedures
11. By signing below, I attest that this appli	cation i	s complete and accurate	:				
Signature of applicant							Date
Please mail completed Ap payable to "Treasurer of V	, /irgin				equired fee c	of \$225 (	check made

Board of Dentistry

9960 Mayland Drive, Suite 300 Henrico, VA 23233-1463

Revised Feb. 9, 2010

FOR OFFICE USE	ONLY			
Date Received	Fee	Pending #	Certification #	Date Issued

# **RHINOPLASTY/SIMILAR PROCEDURES**

1. Name (Last, First, M.I., Suffix, Maiden Name)	2. Virginia Dental License Number:
<ol> <li>Oral and Maxillofacial Residency Program (must be approved by Association)</li> </ol>	the Commission on Dental Accreditation of the American Dental
Association	
at	was completed
by the applicant on the following date	Attach a copy of the certificate.
4. Check the blank space in front of A or B below to indicate	which requirement applies to you, then attach the appropriate
documentation:	
A If the residency program completion date is aft	er July 1, 1996, <u>and</u> training in cosmetic procedures was part
of the residency, attach the following:	or oury 1, 1000, <u>and</u> training in cosmolo procedures was part
	the training provided in rhinoplasty/similar procedures, and,
	cant performed, as primary or assistant surgeon, at least 10
proctored cases in rhinoplasty/similar procedure	35.
OR	
	or to July 1, 1996, and in any case where the residency
program did not include training in cosmetic proce	dures, attach the following: specific to rhinoplasty/similar procedures that include the title
of the course, the dates attended, and the locat	
Attach a copy of the certificate of attendance for	
NOTE: To be approved, the courses must have	
a. an advanced specialty education program in on Dental Accreditation	oral and maxillofacial surgery accredited by the Commission
	ommittee on Medical Education or other official accrediting
body recognized by the American Medical Ass	
	e of its constituent or component societies or other ADA
	CERP) approved for continuing dental education, or
d. the American Medical Association, approved <b>AND</b>	for category 1, continuing medical education.
	n cosmetic surgical procedures within a hospital accredited
by the Joint Commission on Accreditation of I	Healthcare Organizations, or
	fully obscured, for at least 10 cases in rhinoplasty/similar
	r secondary surgeon. At least 5 of the ten cases must have om the proctor that specifies the number of rhinoplasty/similar
procedures proctored.	on the proton that specifies the number of minoplasty/similar

## **BLEPHAROPLASTY/SIMILAR PROCEDURES**

1. Name (Last, First, M.I., Suffix, Maiden Name)	2. Virginia Dental License Number:		
	<u> </u>		
3. Oral and Maxillofacial Residency Program (must be approved by	the Commission on Dental Accreditation of the American Dental		
Association)			
at	was completed		
by the applicant on the following date	Attach a convict the partificate		
	Allach a copy of the certificate.		
4. Check the blank space in front of A or B below to indicate which requirement applies to you, then attach the appropriate documentation:			
of the residency, attach the following:	ter July 1, 1996, <u>and</u> training in cosmetic procedures was part		
	the training provided in blepharoplasty/similar procedures,		
and,			
	icant performed, as primary or assistant surgeon, at least 10		
proctored cases in blepharoplasty/similar proce	dures.		
OR			
B If the residency program completion date is pri	or to July 1, 1996, and in any case where the residency		
program did not include training in cosmetic proce	edures, attach the following:		
1. A list of approved didactic and clinical courses specific to blepharoplasty/similar procedures that include the			
title of the course, the dates attended, and the I			
Attach a copy of the certificate of attendance for			
NOTE: To be approved, the courses must have			
	oral and maxillofacial surgery accredited by the Commission		
on Dental Accreditation	ommittee on Medical Education or other official accrediting		
body recognized by the American Medical As			
c. the American Dental Association (ADA) or one of its constituent or component societies or other ADA			
Continuing Education Recognized Programs (CERP) approved for continuing dental education, or			
d. the American Medical Association, approved	for category 1, continuing medical education.		
AND			
	m cosmetic surgical procedures within a hospital accredited		
by the Joint Commission on Accreditation of Healthcare Organizations, or			
b. Patient operative records with patient names fully obscured, for at least 10 cases in blepharoplasty/similar procedures documenting you as the primary or secondary surgeon. At least 5 of the ten cases must have			
been proctored. Attach a signed statement fro			
blepharoplasty/similar procedures proctored.			

## RHYTIDECTOMY/SIMILAR PROCEDURES

1. Name (Last, First, M.I., Suffix, Maiden Name)	2. Virginia Dental License Number:		
<ol> <li>Oral and Maxillofacial Residency Program (must be approved by the Commission on Dental Accreditation of the American Dental Association)</li> </ol>			
at	was completed		
	Attach a copy of the certificate.		
4. Check the blank space in front of A or B below to indicate which requirement applies to you, then attach the appropriate documentation:			
<ul> <li>A. If the residency program completion date is after July 1, 1996, <u>and</u> training in cosmetic procedures was part of the residency, attach the following:</li> <li>A letter from the program director documenting the training provided in rhytidectomy/similar procedures,</li> </ul>			
<ul><li>and,</li><li>2. Documentation from the program that the appl proctored cases in rhytidectomy/similar procedu</li></ul>	icant performed, as primary or assistant surgeon, at least 10 ures.		
OR			
<ul> <li>B. If the residency program completion date is prior to July 1, 1996, and in any case where the residency program did not include training in cosmetic procedures, attach the following:</li> <li>1. A list of approved didactic and clinical courses specific to rhytidectomy/similar procedures that include the title of the course, the dates attended, and the location of the course. Attach a copy of the certificate of attendance for each course listed.</li> </ul>			
NOTE: To be approved, the courses must have been obtained from one of the following: a. an advanced specialty education program in oral and maxillofacial surgery accredited by the Commission on Dental Accreditation			
<ul> <li>b. a medical school accredited by the Liaison Committee on Medical Education or other official accrediting body recognized by the American Medical Association</li> </ul>			
<ul> <li>c. the American Dental Association (ADA) or one of its constituent or component societies or other ADA Continuing Education Recognized Programs (CERP) approved for continuing dental education, or</li> <li>d. the American Medical Association, approved for category 1, continuing medical education.</li> </ul>			
<ul> <li>2.a. Documentation of current privileges to perform by the Joint Commission on Accreditation of b. Patient operative records with patient names</li> </ul>	fully obscured, for at least 10 cases in rhytidectomy/similar or secondary surgeon. At least 5 of the ten cases must have		

# SUBMENTAL LIPOSUCTION/SIMILAR PROCEDURES

1. Name (Last, First, M.I., Suffix, Maiden Name)	2. Virginia Dental License Number:		
<ol> <li>Oral and Maxillofacial Residency Program (must be approved by the Commission on Dental Accreditation of the American Dental Association)</li> </ol>			
at	was completed		
by the applicant on the following date	Attach a copy of the certificate.		
4. Check the blank space in front of A or B below to indicate which requirement applies to you, then attach the appropriate documentation:			
A. If the residency program completion date is aft of the residency, attach the following:	er July 1, 1996, and training in cosmetic procedures was part		
	the training provided in submental liposuction/similar		
	icant performed, as primary or assistant surgeon, at least 10 r procedures.		
OR			
	or to July 1, 1996, and in any case where the residency		
<ol> <li>program did not include training in cosmetic procedures, attach the following:</li> <li>A list of approved didactic and clinical courses specific to submental liposuction/similar procedures that include the title of the course, the dates attended, and the location of the course.</li> </ol>			
Attach a copy of the certificate of attendance for	each course listed.		
NOTE: To be approved, the courses must have been obtained from one of the following: a. an advanced specialty education program in oral and maxillofacial surgery accredited by the Commission			
on Dental Accreditation b. a medical school accredited by the Liaison Committee on Medical Education or other official accrediting			
body recognized by the American Medical Association c. the American Dental Association (ADA) or one of its constituent or component societies or other ADA			
Continuing Education Recognized Programs (CERP) approved for continuing dental education, or d. the American Medical Association, approved for category 1, continuing medical education.			
AND 2.a. Documentation of current privileges to perform cosmetic surgical procedures within a hospital accredited			
by the Joint Commission on Accreditation of Healthcare Organizations, or b. Patient operative records with patient names fully obscured, for at least 10 cases in submental			
liposuction/similar procedures documenting you as the primary or secondary surgeon. At least 5 of the ten			
cases must have been proctored. Attach a signed statement from the proctor that specifies the number of submental liposuction/similar procedures proctored.			

### BROWLIFT/EITHER OPEN OR ENDOSCOPIC TECHNIQUE/ SIMILAR PROCEDURES

1. Name (Last, First, M.I., Suffix, Maiden Name)	2. Virginia Dental License Number:
3. Oral and Maxillofacial Residency Program (must be approved by Association)	the Commission on Dental Accreditation of the American Dental
at	was completed
by the applicant on the following date	Attach a copy of the certificate.
4. Check the blank space in front of A or B below to indicate documentation:	which requirement applies to you, then attach the appropriate
of the residency, attach the following: 1. A letter from the program director documenting technique/similar procedures, and,	er July 1, 1996, <u>and</u> training in cosmetic procedures was part the training provided in browlift/either open or endoscopic
<ol><li>Documentation from the program that the appli proctored cases in browlift/either open or endos</li></ol>	cant performed, as primary or assistant surgeon, at least 10 copic technique/similar procedures.
OR	
program did not include training in cosmetic proce 1. A list of approved didactic and clinical courses	specific to browlift/either open or endoscopic le of the course, the dates attended, and the location of the
NOTE: To be approved, the courses must have	
<ul> <li>b. a medical school accredited by the Liaison Constrained by the American Medical Association</li> </ul>	
	e of its constituent or component societies or other ADA CERP) approved for continuing dental education, or for category 1, continuing medical education
AND	Tor category 1, continuing medical education.
2.a. Documentation of current privileges to perform by the Joint Commission on Accreditation of I	n cosmetic surgical procedures within a hospital accredited
<ul> <li>b. Patient operative records with patient names endoscopic technique/similar procedures doct</li> </ul>	fully obscured, for at least 10 cases in browlift/either open or umenting you as the primary or secondary surgeon. At least Attach a signed statement from the proctor that specifies the

# **OTOPLASTY/SIMILAR PROCEDURES**

1. Name (Last, First, M.I., Suffix, Maiden Name)	2. Virginia Dental License Number:		
3. Oral and Maxillofacial Residency Program (must be approved by the Commission on Dental Accreditation of the American Dental Association)			
at	was completed		
by the applicant on the following date	Attach a copy of the certificate.		
4. Check the blank space in front of A or B below to indicate documentation:	which requirement applies to you, then attach the appropriate		
	ter July 1, 1996, <b>and</b> training in cosmetic procedures was part		
<ul> <li>of the residency, attach the following:</li> <li>1. A letter from the program director documenting the training provided in otoplasty/similar procedures, and,</li> <li>2. Documentation from the program that the applicant performed, as primary or assistant surgeon, at least 10 proctored cases in otoplasty/similar procedures.</li> </ul>			
OR			
<ul> <li>program did not include training in cosmetic proce</li> <li>1. A list of approved didactic and clinical courses of the course, the dates attended, and the locat Attach a copy of the certificate of attendance for NOTE: To be approved, the courses must have</li> <li>a. an advanced specialty education program in on Dental Accreditation</li> <li>b. a medical school accredited by the Liaison C body recognized by the American Medical Ass</li> <li>c. the American Dental Association (ADA) or on Continuing Education Recognized Programs ( d. the American Medical Association, approved</li> <li>AND</li> <li>2.a. Documentation of current privileges to perforr by the Joint Commission on Accreditation of I</li> <li>b. Patient operative records with patient names procedures documenting you as the primary of</li> </ul>	specific to otoplasty/similar procedures that include the title tion of the course. e each course listed. been obtained from one of the following: oral and maxillofacial surgery accredited by the Commission ommittee on Medical Education or other official accrediting sociation he of its constituent or component societies or other ADA (CERP) approved for continuing dental education, or for category 1, continuing medical education. m cosmetic surgical procedures within a hospital accredited		

# LASER RESURFACING OR DERMABRASION/SIMILAR PROCEDURES

1. Name (Last, First, M.I., Suffix, Maiden Name)	2. Virginia Dental License Number:		
3. Oral and Maxillofacial Residency Program (must be approved by a Association)	the Commission on Dental Accreditation of the American Dental		
at	was completed		
by the applicant on the following date	Attach a copy of the certificate.		
4. Check the blank space in front of A or B below to indicate which requirement applies to you, then attach the appropriate documentation:			
A. If the residency program completion date is after of the residency, attach the following:	er July 1, 1996, <u>and</u> training in cosmetic procedures was part		
<ol> <li>A letter from the program director documenting dermabrasion/similar procedures, and,</li> </ol>	I the training provided in laser resurfacing or		
	icant performed, as primary or assistant surgeon, at least 10 rasion/similar procedures.		
OR			
<ul> <li>B. If the residency program completion date is price program did not include training in cosmetic proceed</li> <li>A list of approved didactic and clinical courses a procedures that include the title of the course, the Attach a copy of the certificate of attendance for NOTE: To be approved, the courses must have a. an advanced specialty education program in c on Dental Accreditation</li> <li>b. a medical school accredited by the Liaison Corbody recognized by the American Medical Ass</li> <li>c. the American Dental Association (ADA) or one Continuing Education Recognized Programs (d. the American Medical Association, approved for the American Medical Association, approved for the American Medical Association, approved for the American Medical Association of current privileges to perform by the Joint Commission on Accreditation of H.</li> </ul>	specific to laser resurfacing or dermabrasion/similar he dates attended, and the location of the course. each course listed. been obtained from one of the following: oral and maxillofacial surgery accredited by the Commission ommittee on Medical Education or other official accrediting sociation he of its constituent or component societies or other ADA (CERP) approved for continuing dental education, or for category 1, continuing medical education. In cosmetic surgical procedures within a hospital accredited Healthcare Organizations, or fully obscured, for at least 10 cases in laser resurfacing or g you as the primary or secondary surgeon. At least 5 of the a signed statement from the proctor that specifies the number		

# PLATYSMAL MUSCLE PLICATION/SIMILAR PROCEDURES

1. Name (Last, First, M.I., Suffix, Maiden Name)	2. Virginia Dental License Number:		
3. Oral and Maxillofacial Residency Program (must be approved by the Commission on Dental Accreditation of the American Dental Association)			
at	was completed		
by the applicant on the following date	Attach a copy of the certificate.		
4. Check the blank space in front of A or B below to indicate which requirement applies to you, then attach the appropriate documentation:			
A. If the residency program completion date is aft of the residency, attach the following:	ter July 1, 1996, <b>and</b> training in cosmetic procedures was part		
<ol> <li>A letter from the program director documenting procedures, and,</li> </ol>	g the training provided in platysmal muscle plication/similar		
	icant performed, as primary or assistant surgeon, at least 10 imilar procedures.		
OR			
<ul> <li>B. If the residency program completion date is prior to July 1, 1996, and in any case where the residency program did not include training in cosmetic procedures, attach the following: <ol> <li>A list of approved didactic and clinical courses specific to platysmal muscle plication/similar procedures that include the title of the course, the dates attended, and the location of the course. Attach a copy of the certificate of attendance for each course listed.</li> <li>NOTE: To be approved, the courses must have been obtained from one of the following: <ol> <li>an advanced specialty education program in oral and maxillofacial surgery accredited by the Commission on Dental Accreditation</li> <li>a medical school accredited by the Liaison Committee on Medical Education or other official accrediting body recognized by the American Medical Association</li> <li>the American Dental Association (ADA) or one of its constituent or component societies or other ADA Continuing Education Recognized Programs (CERP) approved for continuing dental education, or</li> <li>the American Medical Association, approved for category 1, continuing medical education.</li> </ol> </li> <li>2.a. Documentation of current privileges to perform cosmetic surgical procedures within a hospital accredited by the Joint Commission on Accreditation of Healthcare Organizations, or</li> <li>Patient operative records with patient names fully obscured, for at least 10 cases in platysmal muscle plication/similar procedures documenting you as the primary or secondary surgeon. At least 5 of the ten cases must have been proctored. Attach a signed statement from the proctor that specifies the number of platysmal muscle plication/similar procedures proctored.</li> </ol></li></ul>			