



**COMMONWEALTH OF VIRGINIA  
BOARD OF DENTISTRY**

Department of Health Professions  
9960 Mayland Drive, Suite 300  
Henrico, VA 23233-1463  
(804) 367-4538

**ORAL AND MAXILLOFACIAL SURGEON  
REINSTATEMENT OF REGISTRATION OF PRACTICE**

INSTRUCTIONS: Use typewriter or print clearly. If the space provided for any answer is insufficient, the registrant 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.

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 ____-____-____				
Virginia Dental License Number:					

Have you practiced oral and maxillofacial surgery in Virginia since your registration expired?  Yes  NO

You must update your oral and maxillofacial surgery profile to qualify for reinstatement of your registration. To complete your profile, email us at [info@vahealthprovider.com](mailto:info@vahealthprovider.com) or call **804-367-4444**, Mon-Fri, between 8:15 AM and 5:00 PM EST to request instruction to complete your profile online. **Print and attach the confirmation page to this application to show that your profile is current.**

By signing below, I attest that this application is complete and accurate:

\_\_\_\_\_  
Signature of applicant

\_\_\_\_\_  
Date

**Please mail completed form, attachment and the required fee of \$350 (check made payable to "Treasurer of Virginia") to:**

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Board of Dentistry  
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February 9, 2010

**FOR OFFICE USE ONLY**

Date Received	Fee	Rec'd Profile	Registration #	Date Reinstated

