COMMONWEALTH OF VIRGINIA
DEPARTMENT OF HEALTH PROFESSIONS
BOARD OF DENTISTRY
9960 MAYLAND DRIVE, Suite 300
HENRICO, VIRGINIA 23233-1463
(804) 367-4538 www.dhp.virginia.gov/dentistry

INSTRUCTIONS FOR REGISTRATION FOR VOLUNTEER DENTAL PRACTICE

Pursuant to §54.2701.5 of the Code of Virginia and Regulation 18VAC60-21-230(E), the following documentation is required to submit an application for Registration for Volunteer Dental Practice:

___ Completed application submitted to board **at least 15 days prior** to engaging in such practice.

___ Applicants must hold a current, valid unrestricted license to practice dentistry.

___ A copy of a current, valid unrestricted license to practice dentistry.

___ The name of the nonprofit organization, date(s) and location(s). The complete address, including zip code, of the location(s) is required to complete your application.

___ Registration fee: The fee for a Registration for Volunteer Practice is $10 and must be paid with a certified check, cashier's check or money order, made payable to The Treasurer of Virginia. Your application will not be reviewed or considered until you have submitted payment. Pursuant to Regulation 18VAC60-21-230(E), fees are non-refundable.

___ Completed Sponsor Certification for Volunteer Registration form.

COMMONWEALTH OF VIRGINIA

Department of Health Professions – Board of Dentistry

9960 Mayland Drive, Suite 300

Henrico, VA 23233-1463

Phone : 804-367-4538 FAX : 804-527-4428

www.dhp.virginia.gov

APPLICATION FOR REGISTRATION FOR VOLUNTEER DENTAL PRACTICE

INSTRUCTIONS: A completed application shall include the following unless otherwise stated below. An incomplete application will delay the processing of your application. The application fee is $10 and must be paid with a certified check, cashier's check or money order, made payable to **The Treasurer of Virginia**. Your application will not be considered until you have submitted payment. If the space provided for any answer is insufficient, please complete your answer on a separate page, sign & specify the question to which it relates. OMISSIONS OR INACCURACIES ARE GROUNDS FOR REJECTION.

Name (Last, First, M.I., Suffix, Maiden Name):

Date of Birth: _____/_____/_____

Social Security Number OR Virginia DMV Control Number:

Mailing Address (Street and/or Box Number, City, State, Zip Code)

Telephone Number:

Email address:

RECORD OF ALL PROFESSIONAL LICENSURE:

State	Profession	License Number	Issued Date	Expiration Date

Has your license to practice as a dentist or as any other health care professional in any state/jurisdiction ever been suspended or revoked? If yes, give details, jurisdiction(s) and date(s) on a separate page. No _____Yes_____

Date(s) of Volunteer Practice

Full Physical address of Volunteer Practice Location:

Name of Sponsoring Organization:

_____ Remote Area Medical (RAM)

_____ Other: Full name of organization: _____

ATTACH A COMPLETED CERTIFICATION FORM FROM THE SPONSORING ORGANIZATION

Have you ever been convicted of a violation or plead Nolo Contedere, to any federal, state or local statue, regulation 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. No _____ Yes _____

I acknowledge that the licensure exemption sought through this application shall only be valid, in compliance with the Board's regulations, during the limited period that such free health care is made available through the volunteer, nonprofit organization on the dates and at the location filed with the Board.

SIGNATURE AND DATE: _____

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Department of Health Professions
9960 Mayland Drive, Suite 300
Henrico, Virginia 23233-1463
(804) 367-4538 WEB PAGE: www.dhp.virginia.gov/dentistry

SPONSOR CERTIFICATION FOR VOLUNTEER REGISTRATION

APPLICANT: THIS FORM IS TO BE COMPLETED BY A REPRESENTATIVE OF THE NONPROFIT ORGANIZATION SPONSORING YOUR VOLUNTEER PRACTICE.

PRINT CLEARLY OR TYPE:

I _____ certify that _____ is a publicly supported all volunteer, nonprofit organization that sponsors the provision of health care to populations of underserved people.

_____
Signature of Sponsor/Representative

_____
Title of Sponsor Representative

State of _____County/City of _____. Sworn and subscribed to, before this _____date of _____, _____.
Date Month Year

My Commission expires on _____.

_____
Signature of Notary Public