INSTRUCTIONS FOR APPLICATION FOR REACTIVATION OF LICENSE

All required documentation is to be sent to the Board office in a single packet with the application. Please note: Fees are not refundable, Regulation 18 VAC 60-20-40.

Reactivation of License Instructions
Revised Feb. 8, 2010
APPLICATION FOR REACTIVATION OF LICENSE

I hereby make application to reactivate my license to practice Dentistry ($285)_________ or Dental Hygiene ($75)_________ in the Commonwealth of Virginia. The following information in support of my application is submitted with a check or money order payable to the Treasurer of Virginia in the amount of $_________. The fee is non-refundable. Attached are copies certifying completion of ____________ contact hours of approved continuing education pursuant to 18 VAC 60-20-105 (B).

GENERAL INFORMATION - Please provide the information requested below. (Print or Type) Use full name, not initials.

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

E-Mail Address  Fax #

Date of Birth  Social Security Number or DMV Control Number
  _____ _____/_____ _____/______ _____
  _____ _____--_____ _____--______ _____

Virginia License Number  Date First License 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.
Please answer **YES** or **NO** to EACH of the following:  (If you answer yes to any of the questions, please explain in detail below and have certified copies of any applicable orders sent directly to this office.

1. Have you ever had any of the following disciplinary actions taken against your license by any licensing authority in any jurisdiction: placed on probation, suspended, revoked or other disciplinary action?  **YES ______  NO ______**

2. Has your practice ever been the subject of an investigation by any licensing authority?  **YES ______  NO_______**

3. Have you ever been denied a license or certification in a health related field or jurisdiction?  **YES ______  NO_______**

4. Is your license in good standing in all jurisdictions where licensed?  **YES_______  NO_______**

Please respond in full to the following questions.  Please answer **YES** or **NO** to each question.

5. Have you ever been convicted, pled guilty to or pled Nolo Contendere to the violation of any federal, state or other statute or ordinance constituting a felony or misdemeanor? (Including convictions for driving under the influence, but excluding traffic violations)?  **YES ______  No ______.**  If yes, explain below and have a **certified copy** of the court order sent directly to the Board of Dentistry.

6. Do you have a mental, physical or chemical dependency condition which could interfere with your current ability to practice Dentistry/Dental Hygiene  **YES_______  NO_____.**  If yes, explain below and have a letter from your treating licensed professional summarizing diagnosis, treatment and prognosis sent directly to the Board of Dentistry.

**EXPLANATIONS:**
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, 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
NAME OF LICENSEE _____________________       LICENSE NUMBER _______________

PLEASE LIST CONTINUING EDUCATION BELOW COMPLETING ALL INFORMATION AND INCLUDE ALL SUPPORTING DOCUMENTATION

(Refer to Regulation 18 VAC 60-20-50. Requirements for continuing education for approved sponsors)

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<th>DATE (in date order)</th>
<th>NAME OF COURSE</th>
<th>APPROVED SPONSOR</th>
<th>NUMBER OF HOURS</th>
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Revised Feb. 8, 2010

TOTAL HOURS__________