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

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.

INSTRUCTIONS FOR APPLICATION FOR REACTIVATION OF LICENSE

Regulation 18 VAC 60-20-105

_____ **1. Completed Application**. Please be sure that all information is completed on application.

_____ **2. Fee** ($285-Dentist) ($75-Dental Hygienist) Check or money order made payable to Treasurer of Virginia

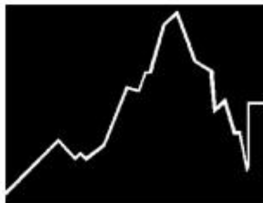
_____ **3. Continuing Education**. Documentation of having completed continuing education hours equal to the requirement for the number of years in which the license has been inactive, not to exceed a total of 45 hours. Of the required hours, at least 15 must be earned in the most recent 12 months and the remainder within the 36 months immediately preceding the application for reactivation. For continuing education requirements, see Regulation 18 VAC 60-20-50. Do not send original documents.

Please submit **copies** of continuing education which indicates:
(1) your name
(2) Name of course
(3) date of course
(4) name of sponsor; and
(5) number of hours

_____ **4. Original** current reports, not older than 6 months, from the (1) Healthcare Integrity and Protection Data Bank (HIPDB) AND (2)National Practitioner Data Bank (NPDB). These are two reports which can be obtained from: www.npdb-hipdb.hrsa.gov, 1-800-767-6732, or NPDB-HIPDB, P.O. Box 10832, Chantilly, Va 20153-0832 and should be submitted with the application.

NOTES:

- Applicants are required to have a current inactive license before reactivation.
- 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.
- 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”.
- After 15 business days of applying, you might check on-line to see if your license has been reactivated by going to www.dhp.virginia.gov and selecting License Lookup.
- Applicants who submit an incomplete application will be notified within 10 business days of receipt that required information is missing.
- Consistent with Virginia law §54.1.2400.02 and the 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 a same address.



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FOR OFFICE USE ONLY

Fee Amount	Approved	Date License Reactivated	Date Inactive Status Taken	License Number

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 in 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 at Time of Original Licensure (Last, First, Maiden)

***<u>Name change:</u> 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 <u>Virginia Department of Motor Vehicles</u>. 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:

VIRGINIA BOARD OF DENTISTRY
APPLICATION AFFIDAVIT
(MUST BE COMPLETED BEFORE A NOTARY PUBLIC)

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 EDCATION BELOW COMPLETING
ALL INFORMATION AND INCLUDE ALL SUPPORTING DOCUMENTATION

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

DATE (in date order)	NAME OF COURSE	APPROVED SPONSOR	NUMBER OF HOURS	BOARD REVIEW

Revised Feb. 8, 2010

TOTAL HOURS___________