Virginia Department of Health Professions
Board of Dentistry

9960 Mayland Drive, Suite 300
Henrico, Virginia 23233
(804) 367-4538 (Tel)
(804) 698-4266 (eFax)
denbd@dhp.virginia.gov
www.dhp.virginia.gov/dentistry

INSTRUCTIONS FOR A FACULTY LICENSE TO TEACH DENTISTRY

A completed application shall include the following, unless otherwise stated below. An incomplete application and/or fee will delay the processing of your application. Incomplete applications remain active for one year from the date of receipt. After one year from date of receipt, you would need to reapply for Virginia licensure. Documents submitted with an application are the property of the Board of Dentistry and cannot be returned.

An applicant for a Faculty License to Teach Dentistry must meet one of the following qualifications:

1. Is a graduate of a dental school or college or the dental department of a college or university, hold a current unrestricted license to practice dentistry in at least one other United States Jurisdiction and have never been licensed to practice dentistry in the Commonwealth; **or**

2. Is a graduate of a dental school or college or the dental department of a college or university, has completed an advanced dental education program accredited by the Commission on Dental Accreditation of the American Dental Association, and has never been licensed to practice dentistry in the Commonwealth.

____ **Application:** Please be sure that all information and questions are completed on the application.

____ **Application Fee:** The fee for a **Faculty License to Teach Dentistry is $400** and must be paid with a certified check, cashier's check or money order, made payable to **The Treasurer of Virginia**. The fee can be used for one year from date of receipt. Pursuant to 18VAC60-21-40(G) all fees are non-refundable. Your application will not be reviewed until you have submitted payment.

____ **Form A: Original** certification of graduation by each dental school which granted you a dental degree or certificate from a dental program accredited by the Commission on Dental Accreditation of the American Dental Association (CODA), or a foreign dental education program. To be accepted the program, which consists of either a pre-doctoral dental education program or at least a 12-month post-doctoral advanced general dentistry program or a post-doctoral dental education program of at least 24 months that includes a **clinical component**. Faxed copies are not acceptable. Applicants must submit a Form A for **each** degree and/or certificate earned from a dental program accredited by CODA or CDAC. The school may use this form or its own form to meet this requirement. The certification must bear the school's seal or be on letterhead and must include the program's CODA/CDAC accreditation status at the time you completed the program. This information is only accepted from programs accredited by CODA or CDAC. Documentation from foreign schools is not required and will not be considered.

____ 4. **Transcript:** Final **original** transcript bearing SEAL, date degree received and registrar's signature. Copies of transcripts, certificates and diplomas are not acceptable. If you completed a post-doctoral program at a hospital which does not maintain transcripts, a letter signed by the Program Director that addresses the coursework and clinical training that you completed is required.

____ 5. **Form B: Chronology** List **ALL** activities, personal and professional, to include all time periods of employment and unemployment, since receiving your doctoral degree or post-doctoral advanced certification. *(Resumes and curriculum vitae are not accepted as substitutes for completing the chronological listing on Form B and will not be considered.)*

____ 6. **Form C: Original** certification of licensure status from every jurisdiction in which you currently hold or have ever held a license/registration/certification to practice as a dentist or as another health care professional. Copies of permits are not accepted. Certifications cannot be older than 6 months from date prepared.

Applicants who have not completed a CODA accredited dental program must hold a current, unrestricted license to practice dentistry in at least one other United States jurisdiction, to qualify for a faculty license.

____ 7. **Scores:** An **original** grade card **indicating passage of all parts of the National Board Dental Examination** issued by the Joint Commission on National Dental Examinations is required. Copies of grade cards are not accepted.

____ 8. **Original NPDB:** current report, not older than 6 months from date prepared, must be obtained by Self Query from the National Practitioner Data Bank (NPDB), which may be requested through their website at www.npdb.hrsa.gov. There is a fee for this report. ***This report from NPDB is required from all applicants, without exception*** *(Regulation 18VAC60-21-190.3)*.

____ 9. **Original** letter from the dean or program director of the dental program, on letterhead, verifying that the applicant is being hired by the program which includes an assessment of the applicant's clinical competency and clinical experience that qualifies the applicant for a faculty license.

____ 10. Please be aware that your signed and notarized application affidavit authorizes the release of confidential information, affirms that your application is complete and correct, and attests that you have read, understand, and will remain current with the laws and regulations governing the practice of dentistry in Virginia. Review the laws and regulations via the "Laws and Regulations" tab at www.dhp.virginia.gov/dentistry.

____ 11. **Name Change:** Documentation must be provided to show each name change, if your name has ever been changed since graduation from a CODA or CDAC accredited program or were licensed in other jurisdictions or other than what is listed on your application. Photocopies of marriage licenses or court orders are accepted.

____ 12. **Address of Record and Publically Disclosable Address:** 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 same address.

Notes:

- **The holder of a Faculty License to Teach Dentistry may only practice dentistry within educational facilities owned or operated by or affiliated with the dental school or program. A licensee who is qualified based on educational requirements for a specialty board certification shall only practice in the specialty for which he is qualified and may receive fees for service but cannot practice privately.**

- Completed applications cannot be edited once they have been submitted.

- If your Virginia License is not issued within 6 months of the date of the NPDB (National Practitioner Databank) Self Query Report and certification of state licensure, you will be asked to submit a current NPDB Self Query Report and current state licensure certification before your application can be reviewed.

- **DEA Registration**: Applicants must have a dental license prior to applying for a DEA License. Requests for an application in Virginia should be made to the following: Drug Enforcement Administration, Attn: Registration Section/ODR, P.O. Box 2639, Springfield, VA 22152-2639; 1-800-882-9539; www.deadiversion.usdoj.gov

- To receive notice that your supporting documents have been delivered to the board, it is suggested that the documents be mailed by Fed-Ex or UPS with "Delivery Confirmation".

- Applicants will be notified of missing application items within approximately 15 business days of receipt of an application. Once your application is complete, allow 30 business days processing time.

Related contact information:

National Practitioner Data Bank
P.O. Box 10832
Chantilly, VA 20153
1-800-767-6732
www.npdb.hrsa.gov

National Board Scores
American Dental Association
Commission on Dental Accreditation
211 East Chicago Avenue
Chicago, IL 60611-2678
www.ada.org.en/jcnde/examinations/

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APPLICATION FOR A FACULTY LICENSE TO TEACH DENTISTRY Page 1

INSTRUCTIONS: Type or print clearly. Complete all sections. If the space provided for any answer is insufficient, complete your answer on a separate page, specify the number of the question to which it relates, sign the page and enclose it with the application.

I. GENERAL INFORMATION: COMPLETE ALL SECTIONS (PRINT OR TYPE)

Name: Last*	First	Middle/Maiden	Suffix

Address of record (Mailing Address)	City	State	Zip Code	Telephone Number
Publically Disclosable Address	City	State	Zip Code	Telephone Number

Email Address	Fax#

Date of Birth	**Social Security Number or Virginia DMV control Number****
_____/_____/_____ Month Day Year	___ ___ ___---___ ___--___ ___ ___ ___

DDS/DMD GRADUATION DATE	PROFESSIONAL DEGREE	CODA/CDAC APPROVED DENTAL SCHOOL/CITY/STATE
____ ____ ____ Month Day Year		
RESIDENCY/SPECIALTY GRADUATION DATE	RESIDENCY/SPECIALTY DEGREE or CERTIFICATE	CODA/CDAC APPROVED DENTAL SCHOOL/CITY/STATE
____ ____ ____ Month Day Year		

APPLICANTS DO NOT USE SPACES BELOW THIS LINE – FOR OFFICE USE ONLY

DATE RECEIVED	CHRONOLOGY (FORM B)	NATIONAL PRACTITIONER DATA BANK	NATIONAL BOARD

TRANSCRIPT	CERTIFICATION (EDUCATION) (FORM A)

CERTIFICATION (LICENSE FROM OTHER STATES (Form C or LETTER)

***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.**

FEE AMOUNT	APPLICANT #	LICENSE #	DATE ISSUED

II. ALL EXAMINATIONS Please answer all "exam" questions "1" through "8"

1. Southern Regional Testing Agency (SRTA) –Exam Site _____ _____/_____/_____ Month/ Day / Year
   [ ] Passed [ ] Failed [ ] Never Taken [ ] Taken more than once (attach explanation)

2. Western Regional Examining Board (WREB) –Exam Site _____ _____/_____/_____ Month/ Day / Year
   [ ] Passed [ ] Failed [ ] Never Taken [ ] Taken more than once (attach explanation)

3. North East Regional Board (NERB/CDCA) –Exam Site _____ _____/_____/_____ Month/ Day / Year
   [ ] Passed [ ] Failed [ ] Never Taken [ ] Taken more than once (attach explanation)

4. Central Regional Dental Testing Services, Inc. (CRDTS) –Exam Site_____ _____/_____/_____ Month/ Day / Year
   [ ] Passed [ ] Failed [ ] Never Taken [ ] Taken more than once (attach explanation)

5. Council of Interstate Testing Agencies, Inc. (CITA) –Exam Site_____ _____/_____/_____ Month/ Day / Year
   [ ] Passed [ ] Failed [ ] Never Taken [ ] Taken more than once (attach explanation)

6. State of _____ –Exam Site_____ _____/_____/_____ Month/ Day / Year
   [ ] Passed [ ] Failed [ ] Never Taken [ ] Taken more than once (attach explanation)

7. National Board Examination: (Original grade cards are required) _____/_____/_____ Month/ Day / Year
   [ ] Passed [ ] Failed [ ] Never Taken [ ] Taken more than once (attach explanation)

8. [ ] Never Taken a clinical examination (attach explanation)

The Board must receive an original score card or report from the testing agency for each examination reported above.

III. APPLICANT HISTORY: ALL QUESTIONS MUST BE ANSWERED.
If any of the following questions are answered "YES", explain and substantiate with documentation. Letters must be submitted by your attorney regarding malpractice suits. Letters must be submitted by any treating professionals regarding health treatment and shall include diagnosis, treatment and prognosis.

1. Did you relocate with a spouse who is the subject of a military transfer to the Commonwealth of Virginia? If "YES", include a copy of the official military orders with the application. [ ] Yes [ ] No

2. Are you active-duty military? If "YES", include a copy of your official military orders with the application. [ ] Yes [ ] No

3. List in chronological order including months and years, the dental school(s) attended (include specialty and advanced programs):

Months & Years	Name of Dental School (ADA-CODA)	Passed/Failed
_____ to _____	_____	_____
_____ to _____	_____	_____
_____ to _____	_____	_____

4. List all jurisdictions in which you currently hold or have ever held a license/registration/certification to practice as a dentist or as another health care professional.

Jurisdiction	License Number	Date Issued	Expiration Date
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

5. Have you ever been denied a license, or the privilege of taking a dental licensure/competency examination by a licensing authority? If "YES", give detail(s), jurisdiction(s) and date(s). [ ] Yes [ ] No

_____

_____

6. Have you ever been convicted of a violation or plead Nolo Contendere, to any federal, state or local statute, regulations or ordinance, or entered into any plea bargaining relating to a felony or misdemeanor? (Excluding traffic violations, except convictions for driving under the influence). [ ] Yes [ ] No

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.

_____

_____

7. Have you had any malpractice suits brought against you in the past ten (10) years? [ ] Yes [ ] No

If "YES", please provide details for each pending or closed case, list additional claim(s) **on a separate page**, and provide a letter from your attorney explaining each case.

Claimant:_____ Date of Incident_____

Name of Defense Attorney:_____

Settlement or Verdict Amount:_____

Name of Involved Insurance Company:_____

Brief description of the claim:_____

_____

_____

Additional licensure questions:

1. A. Within the past five years, have you exhibited any conduct or behavior that could call into question your ability to practice in a competent and professional manner? If "YES", please provide a full explanation. [ ] Yes [ ] No

_____

_____

B. Within the past five years, have you sought or been directed to seek treatment for your conduct or behavior? If "YES", please provide a full explanation. [ ] Yes [ ] No

_____

_____

2. Within the past five years, have you been disciplined by any entity? [ ] Yes [ ] No

A. If "YES" please provide a full explanation and any associated orders or letters from the entity.

_____

_____

B. Within the past five years, have you sought or been directed to seek treatment for your conduct or behavior? If "YES" please provide a full explanation and any associated orders or letters from the entity. [ ] Yes [ ] No

_____

_____

3. Do you currently have any physical condition or impairment that affects or limits your ability to perform any of the obligations and responsibilities of professional practice in a safe and competent manner? [ ] Yes [ ] No

*****"Currently" means recently enough so that the condition could reasonably have an impact on your ability to function as a practicing Dentist. If "YES", please provide a full explanation. **Note:** the Board may request a letter from your current treatment provider addressing your current condition and ability to safely practice. You may consider providing this documentation with your application, or have your provider send this documentation directly to the Board.

_____

_____

4. Do you currently* have any mental health condition or impairment that affects or limits your ability to perform any of the obligations and responsibilities of professional practice in a safe and competent manner? [ ] Yes [ ] No

   *"Currently" means recently enough so that the condition could reasonably have an impact on your ability to function as a practicing Dentist. If "YES", please provide a full explanation. **Note:** the Board may request a letter from your current treatment provider addressing your current condition and ability to safely practice. You may consider providing this documentation with your application, or have your provider send this documentation directly to the Board.

   _____

   _____

5. Do you currently* have any condition or impairment related to alcohol or other substance use that affects or limits your ability to perform any of the obligations and responsibilities of professional practice in a safe and competent manner? [ ] Yes [ ] No

   *"Currently" means recently enough so that the condition could reasonably have an impact on your ability to function as a practicing Dentist. If "YES", please provide a full explanation. **Note:** the Board may request a letter from your current treatment provider addressing your current condition and ability to safely practice. You may consider providing this documentation with your application, or have your provider send this documentation directly to the Board.

   _____

   _____

6. Within the past five years, have any conditions or restrictions been imposed upon you or your practice to avoid disciplinary action by any entity? [ ] Yes [ ] No

   If "YES", please provide a full explanation and any associated orders or letters from the entity.
   Note: the Board may request a letter from your current treatment provider addressing your current condition and ability to safely practice. You may consider providing this documentation with your application, or have your provider send this documentation directly to the Board.

   _____

   _____

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/dentistry, 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 _____.

SEAL

_____
Signature of Notary Public

_____
Print Name

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FORM A
CERTIFICATION OF DENTAL SCHOOL

Applicant: Enter **only** your name and graduation date below, then send this form to the Dean or Director of each Dental School or Program which granted you a degree or certificate.

APPLICANT _____ **GRADUATION DATE**:_____

DEAN/PROGRAM DIRECTOR: Please provide certification that the applicant named above received a dental degree or certificate from your program and certification that the program completed was accredited by the Commission on Dental Accreditation of the ADA (CODA) or the Commission on Dental Accreditation of Canada (CDAC) at the time the applicant completed the program. The certification may be provided by completing this form or by providing a letter with all the information requested on this form. Either document must bear the school's seal.

Certifications made prior to the applicant's graduation cannot be accepted.

NAME OF SCHOOL: _____

NAME OF PROGRAM:_____

PROGRAM'S CODA/CDAC ACCREDITATION STATUS ON THE DATE THE DEGREE OR CERTIFICATION WAS GRANTED:

A1:	Approval (without reporting requirements)	[ ]
A2:	Approval (with reporting requirements)	[ ]
IA:	Initial accreditation	[ ]
DIS:	Accreditation voluntarily discontinued	[ ]
WDRN:	Accreditation withdrawn	[ ]
X:	Intent to withdraw accreditation	[ ]
T:	Program is in Teach-Out by institution	[ ]
NE:	Required period of non-enrollment	[ ]

DEGREE or CERTIFICATION GRANTED:_____

DATE GRANTED: _____/_____/_____
Month Day Year

By affixing my signature below, I certify that the applicant named above is a graduate and a holder of a diploma or a certificate from a CODA/CDAC accredited dental program.

SEAL

_____
Signature

_____
Print Name

_____
Title

_____
Date

DEAN/REGISTRAR: Please provide the applicant an original, final transcript of this alumni record, to include courses, grades, degree or certificate received, and date the degree or certificate was conferred, which bears the certified signature of the registrar and has the college seal affixed.

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FORM B
CHRONOLOGY

NAME OF APPLICANT:_____

Every applicant must provide a complete chronological, personal and professional history of all activities you have engaged in since receiving your degree or certification, including teaching positions, all periods of non-professional activity or employment, volunteer work and all periods of unemployment. **Curriculum vitae and resumes are not accepted as substitutes for completing the chronological listing and will not be considered.**

Form B may be photocopied if additional space is needed.

FROM Month/Year	**TO** Month/Year	**POSITION/ACTIVITY**	**Employer/Contact Person for practice verification and the person's Complete Address, and Telephone #**

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FORM C
CERTIFICATION OF DENTAL BOARDS

Please forward one form to each state dental/dental hygiene board where you hold or have ever held a dental/dental hygiene license. Some states require a fee, paid in advance, for providing this information. To expedite, you may wish to contact the applicable state board(s). Form C may be photocopied if copies are needed.

I am making application for licensure in Virginia by:

[ ] Examination for Dental License	[ ] Examination for Dental Hygiene License	[ ] Dental Restricted Volunteer License
[ ] Credentials for Dental License	[ ] Credentials for Dental Hygiene License	[ ] Dental Hygiene Restricted Volunteer License
[ ] Dental Faculty License	[ ] Dental Hygiene Faculty License	[ ] Dental Reinstatement
[ ] Dental Temporary Permit	[ ] Dental Hygiene Temporary Permit	[ ] Dental Hygiene Reinstatement

I, was granted License Number _____, on _____ by the State of
Month Date Year.

_____. The Virginia Board of Dentistry requires that I submit evidence of the status of my license. You are hereby authorized to release any information in your files, favorable or otherwise directly to the **Virginia Board of Dentistry** at **9960 Mayland Drive, Suite 300, Henrico, Virginia 23233** or **denbd@dhp.virginia.gov**. Your early attention is appreciated.

_____ _____ _____
Applicant's Signature Applicant's Typed/Printed Name Applicant's Address

_____

Executive Officer of the Board: please send this form directly to the Virginia Board of Dentistry.

State of _____ Name of Licensee_____

Graduate of_____ License #_____Issued_____

By: [ ] Examination* [ ] Credentials [ ] Reciprocity with the State of _____ [ ] Endorsement with the State of _____

*If licensed by a state administered examination, please provide a score card or report which shows that testing included live patients.

License is: [ ] Current-Expires_____ [ ] Active [ ] Inactive [ ] Lapsed-Expired_____

Has applicant's license ever been disciplined, suspended or revoked [ ] NO [ ] YES

If "YES", give details and attach supporting documentation (Finding of Fact, Conclusions of Law, Orders):_____

_____

_____

Comments, if any:_____

_____

SEAL

_____ _____ _____
Signature Title Date

_____
Print Name