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 TEMPORARY RESIDENT'S LICENSE

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.

____ 1. **Application:** Please be sure that all information and questions are completed on the application.

____ 2. **Application Fee:** The fee for a **temporary resident's license by examination is $60** 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.

____ 3. **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.)*

____ 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 that addresses the coursework and clinical training that you completed, signed by the Program Director, is required.

____ 5. **Form C: Original** licensure status and certification 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.

____ 6. **Form D:** Recommendation from the dean of the dental school or the director of the accredited advanced dental education program specifying the applicant's acceptance as an intern, resident or post-doctoral certificate or degree candidate. The beginning and ending dates of the internship, residency or post-doctoral program must be specified.

____ 7. 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:** A 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. 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.

____ 10. **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:

- Completed applications cannot be accessed or 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.
- **The temporary license permits the holder to practice only in the hospital or outpatient clinics that are recognized parts of an advanced dental education program. The temporary license holder is prohibited from practicing outside of the advanced dental education program.**
- A Virginia address must be provided before a Temporary Resident's License can be issued.
- 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. P.O. Box 10832
Chantilly, VA 20153
1-800-767-6732
www.npdb.hrsa.gov

National Board Scores
Joint Commission on National Dental Examinations
211 East Chicago Avenue
Chicago, IL 60611-2678
1-800-232-1694
www.ada.org/jcnde/examinations

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APPLICATION TEMPORARY RESIDENT'S LICENSE 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	RECOMMENDATION FROM DEAN/DIRECTOR (FORM D)	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. 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	Number	Type	Date Issued	Exp. Date
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

5. Have you ever been dropped, suspended, expelled, or disciplined by any school or college for any cause whatever? If "YES", give detail(s), jurisdiction(s) and date(s). [ ] Yes [ ] No

_____

_____

6. 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

_____

_____

7. 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.

_____

_____

8. 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. A. Within the past five years, have you been disciplined by any entity? If "YES" please provide a full explanation and any associated orders or letters from the entity. [ ] 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 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? 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. _____ _____	[ ] Yes [ ] No

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 B
CHRONOLOGY

APPLICANT NAME:_____

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

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FORM D
RECOMMENDATION MEMORANDUM

MEMORANDUM:

TO: Virginia Board of Dentistry

FROM: Dean of dental school or the director of the accredited graduate program

Name of Training Institute: _____

Complete Mailing address: _____

_____

Telephone: _____

This is to certify that _____ will be enrolled in _____
Name of resident Name of Program

_____ at _____, _____
Name of dental school Street Address

_____
City, State and Zip Code

From _____ with an expected completion of date of _____
(Month/Day/Year) (Month/Day/Year)

Dr. _____ is a graduate of _____
Name of resident Dental School

_____
Signature

_____
Title

_____
Date