

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

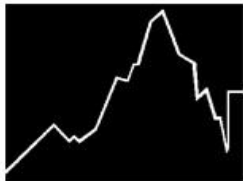
## Application Instructions for Restricted Volunteer Dental Hygiene License

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 are kept for one year then destroyed.

- \_\_\_\_\_ 1. **Application:** Please be sure that all information and questions are completed on the application.
- \_\_\_\_\_ 2. **Application Fee:** The fee for a Restricted Volunteer Dental Hygiene license is \$25 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 18VAC60-25-30(F), fees are nonrefundable.
- \_\_\_\_\_ 3. **Form B:** List **ALL** activities since receiving your dental hygiene degree or certification. (*Resumes and curriculum vitas are not accepted as substitutes for completing the chronological listing and will not be considered.*) **Applicants must have had at least 5 years of clinical practice in Virginia; another jurisdiction of the United States or federal civil or military service.**
- \_\_\_\_\_ 4. **Form C: Original** licensure verification from any jurisdiction in which you currently hold or have ever held a license/registration/certification to practice as a dental hygienist or as any other health care professional. Copies of permits are not accepted. Verification cannot be older than 6 months from date prepared. **Applicants must have held an unrestricted dental hygiene license in Virginia or another state, as a licensee in good standing at the time the license expired or became inactive.**
- \_\_\_\_\_ 5. 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 and understand and will remain current with the laws and regulations governing the practice of dentistry in Virginia. In addition, it verifies that no remuneration will be received directly or indirectly for dental or dental hygiene services.
- \_\_\_\_\_ 6. **Name Change:** Documentation must be provided to show each name change if your name has ever been changed from the time you attended school or were licensed in other jurisdictions or other than what is listed on your application. Photocopies of marriage licenses or court orders are accepted.
- \_\_\_\_\_ 7. **Original**, 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](http://www.npdb.hrsa.gov). There is a fee for this report. ***This report from NPDB is required from all applicants, without exception.*** (Regulation 18VAC60-25-130A.3)

## NOTES:

- **A person holding a restricted volunteer dental hygiene license shall practice only under the direction of a dentist who holds an unrestricted license in Virginia and only treat patients who have been screened by the approved clinic and are eligible for treatment.**
- You might obtain the Virginia laws and the regulations governing the practice of dental hygiene at [www.dhp.virginia.gov/dentistry](http://www.dhp.virginia.gov/dentistry).
- To receive notice that your supporting documents have been delivered to the board, it is suggested that the documents be mailed by “Certified Mail-Return Receipt Requested” or with “Delivery Confirmation”.
- Within approximately 10 business days of receipt of an application, applicants will be notified of missing application items.
- Documents submitted with an application are the property of the board and cannot be returned.
- **PLEASE NOTE:** If your Virginia License is not issued within six months of the Board’s receipt of parts of the application, certain portions of the application may need to be resubmitted before your application can be reviewed.
- Consistent with Virginia law §54.1.2400.02 and 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.



Commonwealth of Virginia  
 Board of Dentistry  
 Department of Health Professions  
 9960 Mayland Drive, Suite 300  
 Henrico, VA 23233-1463  
 804-367-4538  
 www.dhp.virginia.gov/dentistry

## APPLICATION FOR RESTRICTED VOLUNTEER DENTAL HYGIENE LICENSE

**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.

### 1. GENERAL INFORMATION

*Name: Last		First	Middle/Maiden	Suffix
Address of Record (Mailing Address)		City	State	Zip
Telephone Number				
Public Disclosable Address		City	State	Zip
Telephone Number				
Email Address			Fax #	
Date of Birth ____/____/____		Social Security Number or <b>Virginia</b> DMV Control Number ____-____-____		
Dental Hygiene Graduation Date  Month    Date    Year	Degree or Certificate	ADA-Coda Approved Dental School	City/State	
<b>FOR OFFICE USE ONLY:</b>				
Date Received	Form AA	Form B	Form C –Certification of Licensure	
____ National Practitioner Data Bank				
Fee	APPLICANT #	LICENSE #	DATE 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.

**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.**

a. List in chronological order including months and years, the dental hygiene school(s) attended:

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

b. List all jurisdictions in which you have ever held a license/registrations/certification to practice dental hygiene or as any other health care professional.

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

c. Have you ever been dropped, suspended, expelled, or disciplined by any school or college for any cause whatever? If yes, give details, schools(s), address (es) and date(s) on a separate page. [ ] Yes [ ] No

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

\_\_\_\_\_  
\_\_\_\_\_

e. Have you ever failed a dental hygiene licensing examination(s)? If yes, give details, jurisdiction(s) and date(s). [ ] Yes [ ] No

\_\_\_\_\_

f. Have you ever been convicted of a violation or plead Nolo Contedere, 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). 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. [ ] Yes [ ] No

g. Have you ever voluntarily surrendered your clinical privileges while under investigation, been censured or warned or been requested to withdraw from the staff of any hospital, nursing home other health care facility, or any health care provider? If yes, give details, jurisdictions(s) and date(s) on a separate page. [ ] Yes [ ] No

h. Have you ever had any of the following disciplinary actions taken against your license to practice dental hygiene, Medicare, Medicaid, or are any such actions pending: suspension/revocations, or probations, or reprimand/cease and desist, or monitoring of practice, or limitation placed on scheduled drugs? If yes, give details, jurisdiction(s) and date(s) on a separate page. [ ] Yes [ ] No

- i. Have you ever had any membership in a professional society revoked, suspended or sanctioned in any manner? If yes, give details, jurisdiction(s) and date(s) on a separate page. [ ] Yes [ ] No
- j. Have you ever been a defendant in a military court martial or received medical or other than honorable discharge? If yes, give details, jurisdiction(s) and date(s) on a separate page. [ ] Yes [ ] No
- k. Have you ever had any malpractice claims brought against you? If yes, give outcome, details, jurisdiction and dates for each claim on a separate page, and provide a letter from your attorney explaining each case. [ ] Yes [ ] No
- l. Have you, within the last two (2) years, been physically or emotionally dependent upon the use of alcohol/drugs or been treated by, consulted with, or under the care of a professional for any substance abuse? If yes, give details, jurisdiction(s) and date(s) on a separate page and provide a letter of explanation from the treating professional(s), including a summary of diagnosis, treatment and prognosis. [ ] Yes [ ] No
- m. Have you, within the last two (2) years, received treatment for, or been hospitalized for a nervous, emotional or mental disorder? If yes, give details, jurisdiction(s) and date(s) on a separate page, and provide a letter of explanation from the treating professional(s), including a summary of diagnosis, treatment and prognosis. [ ] Yes [ ] No
- n. Do you have a physical disability, disease, or diagnosis which could affect your performance or professional duties? If yes, provide a letter of explanation from the treating professional(s), including a summary of diagnosis, treatment, and prognosis. [ ] Yes [ ] No
- o. Have you been adjudged mentally incompetent, or been voluntarily or involuntarily committed to a mental institution within the last five (5) years? If yes, give details, jurisdiction(s) and date(s) on a separate page, and provide certified copies of all applicable court documents. [ ] Yes [ ] No
- p. Did you relocate with a spouse who is the subject of a military transfer to the Commonwealth of Virginia? [ ] 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](http://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



**COMMONWEALTH OF VIRGINIA**

**BOARD OF DENTISTRY**

Department of Health Professions

9960 Mayland Drive, Suite 300

Henrico, VA 23233-1463

(804) 367-4538 [www.dhp.virginia.gov/dentistry](http://www.dhp.virginia.gov/dentistry)

**FORM C**

**CERTIFICATION OF DENTAL HYGIENE 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: Dental Hygiene Restricted Volunteer License**

I, \_\_\_\_\_, was granted License Number \_\_\_\_\_ on \_\_\_\_\_, by the State of \_\_\_\_\_. The Virginia Board of Dentistry requests that I submit evidence that my license in the State of \_\_\_\_\_ is in good standing. You are hereby authorized to release any information in your files, favorable or otherwise directly to the Virginia Board of Dentistry. Your early attention is appreciated.

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Applicant's Typed/Printed Name

\_\_\_\_\_  
Applicant's Address

**Executive officer of State Board: If no disciplinary action has been taken, please complete and return this form to the applicant. If disciplinary action has been taken, please send the form directly to the Virginia Board of Dentistry.**

State of \_\_\_\_\_ Name of Licensee \_\_\_\_\_

Graduate of \_\_\_\_\_ License # \_\_\_\_\_ Issued \_\_\_\_\_

By  Reciprocity  Examination  If licensed by state clinical exam, provide year and check her if exam included treatment of live patient \_\_\_\_\_  Endorsement with the State of \_\_\_\_\_

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): \_\_\_\_\_

Derogatory information, if any: \_\_\_\_\_

Comments, if any: \_\_\_\_\_

SEAL

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Title

\_\_\_\_\_  
Date