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 REINSTATMENT OF DENTAL ASSISTANT II REGISTRATION

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. **Reinstatement Application**: Please be sure that all information is completed on the application.

_____ 2. **Fee for lapsed registration:** The reinstatement fee for a **Dental Assistant II Registration is $125** and must be paid with a certified check, cashier's check or money order, made payable to the **Treasurer of Virginia**.

Fee for revocation or suspension of registration: The reinstatement fee for a previously revoked Dental Assistant II registration is **$300** and the reinstatement fee for a previously indefinitely suspended Dental Assistant II registration is **$250**.

_____ 3. Evidence of a current credential as a **Certified Dental Assistant** (CDA) conferred by the Dental National Board (DANB) or another certification from a credentialing organization recognized by the American Dental Association and acceptable to the board.

_____ 4. **Evidence of Continuing Clinical Competence:** The applicant must include documentation in the application sufficient to demonstrate continuing clinical competence in the duties for which the applicant is requesting reinstatement of, which may include documentation of active practice in another state or in federal service, or a refresher course offered by an educational program accredited by the Commission on Dental Accreditation of the American Dental Association. The optional employment verification form on page 7 may be used to document active practice.

_____ 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, 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.

_____ 6. **Name Change:** Documentation must be provided to show each name change(s) if your name has ever been changed from the most recent time you held an active registration in Virginia or in other jurisdictions or other than what is on record with the Virginia Board of Dentistry. Photocopies of marriage licenses or court orders are accepted.

_____ 7. **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:

- If your Virginia License is not reinstated 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.
- To receive notice that your application has been delivered to the Board, it is suggested that the documents be mailed by "Certified Mail-Return Receipt Requested" or 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.

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APPLICATION FOR REINSTATEMENT OF DENTAL ASSISTANT II REGISTRATION 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 Number:
Date of Birth _____/_____/_____ Month Day Year	Social Security Number or Virginia DMV Control Number on record** ____ ____ ____--____ ____ --____ ____ ____ ____

Virginia DAII Registration Number:	Date of Expiration:	Name at time of Original Registration*

Reinstatement of Registration is sought for (check all that apply):

____ 1. Performing pulp capping procedures
____ 2. Packing and carving of amalgam restorations;
____ 3. Placing and shaping composite resin restorations with a slow speed hand piece;
____ 4. Taking final impressions;
____ 5. Use of a non-epinephrine retraction cord;
____ 6. Final cementation of crowns and bridges after adjustment and fitting by the dentist.

Please check the applicable box below:

☐ REINSTATEMENT REQUESTED DUE TO LAPSE OF REGISTRATION

☐ REINSTATEMENT REQUESTED DUE TO SUSPENSION

☐ REINSTATEMENT REQUESTED DUE TO REVOCATION

***Name change:** **Documentation must be provided to show name change(s) if name has ever been changed from the time you were licensed in Virginia or 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.**

FOR OFFICE USE ONLY

FEE AMOUNT	APPLICANT #	DATE OF REINSTATEMENT	LICENSE #

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. Have you practiced dental assisting since the expiration of your registration in the Commonwealth of Virginia or in another jurisdiction? If "YES", give location._____ [ ] Yes [ ] No

4. Has any of your work since the expiration of your registration been in any field other than the field of dentistry? If "YES", give details, jurisdictions(s) and date(s). [ ] Yes [ ] No

   _____

   _____

5. List all jurisdictions in which you currently hold or have ever held a license / registration / certification to practice in the field of dentistry or in any other health care profession:

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

6. Have you ever been convicted of a violation of or pled Nolo Contendere to any federal, state or local statute, regulation 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

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 and any associated orders or letters. [ ] 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. [ ] 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 5 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 copy of a current participation contract and summary of compliance and/or documentation of successful completion. You may consider providing this documentation with your application, or have the program 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 assisting. 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 _____.

_____
Signature of Notary Public

SEAL

_____
Print Name

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EMPLOYMENT VERIFICATION

(Optional Form)

(MUST BE COMPLETED BEFORE A NOTARY PUBLIC)

Name of Employing Dentist(s) or Agency:_____

Complete Mailing Address: _____

Telephone Number:_____ Fax Number:_____

Email Address_____

"I, _____ D.D.S./D.M.D./agency representative,
(Print name & Title of the Employing Dentist or Agency Representative)

certify that _____, was employed by me as a _____
(Print Applicant/Employee Name) **(Print Job Title)**

_____ from _____/____/_____ to _____/____/_____, in the clinical, ethical and legal
Month Day Year Month Day Year

practice of a _____.

_____ _____
Dentist's/Agency Representative Signature Date

State of _____

County/City of _____

Sworn and subscribed to, before me, this _____day of _____, _____.
Day Month Year

My commission expires on _____.
Month Day Year

_____
Signature of Notary Public

SEAL/STAMP

_____
Print Name