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

A completed application shall include the following unless stated below. An incomplete application and/or fee will delay the processing of your application. Incomplete applications are kept for one year then destroyed.

INSTRUCTIONS FOR REINSTATMENT OF DENTAL HYGIENE LICENSE:

_____ **1.Reinstatement Application**: Please be sure that all information is completed on the application.

_____ 2.**Fee for applicant due to lapse of license:** The reinstatement fee for a **dental hygiene license** is $200 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 18VAC60-25-30(F), all fees are non-refundable. Your application will not be reviewed until you have submitted payment.

Fee for applicant due to previously revoked or indefinitely suspended license: The reinstatement fee for a previously revoked dental hygiene license is **$500** and the reinstatement fee for a previously indefinitely suspended dental hygiene license is **$400**.

_____ **3.Form B Chronology**: List **ALL** activities since receiving your degree or certification. (*Resumes and curriculum vitas are not accepted as substitutes for completing the chronological listing and will not be considered.*

_____ **4.Form C**: **Original** licensure verification from any jurisdiction in which you currently hold or have ever held a license/registration/certification to practice dentistry or as another health care professional. Copies of permits are not accepted. Verification cannot be older than 6 months from date prepared.

_____ **5.Original,** current report, not older than 6 months, must be obtained by Self Query from the National Provider Data Bank (NPDB), which may be requested through their website at http://www.npdb.hrsa.gov/. There is a fee for this report. **This report from the NPDB is required from all applications, without exception** Regulation 18VAC60-25-130.A(3)

____ **6.**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.

____ **7.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 license in Virginia or were licensed in other jurisdictions or other than what is listed on your application. Photocopies of marriage licenses or court orders are accepted.

_____ **8.Continuing Education:** You must submit documentation of having completed continuing education (CE) hours equal to the requirement for the number of years in which the license has not been active, 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 reinstatement. Do not send original documents.

Submitted CE documentation must include the following:

- Your name
- Name of course completed
- If the subject matter of the course is not evident in the title, you must also submit the sponsor's course description.
- Date(s) in which you completed the course
- Name of the course sponsor; and
- The number of CE credit hours earned

PLEASE NOTE:

- **To qualify for reinstatement of an expired license, the applicant must include documentation in the application sufficient to demonstrate continuing competence. Continuing education hours and evidence of active practice in another state or in federal service, recent passage of a clinical competency examination, a refresher program offered by a program accredited by the Commission on Dental Accreditation of the American Dental Association or current specialty board certification are considered in determining continuing competence. Completion of only home study, journal or internet courses is generally not sufficient to demonstrate continuing competence.**

- If your Virginia license has not been reinstated within six months of the Board's receipt of the application, certain portions of the application may need to be resubmitted before your application can be reviewed.

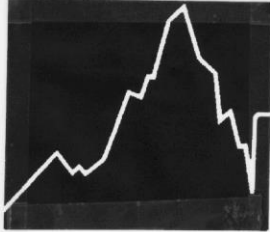
- You might obtain the Virginia laws and the regulations governing the practice of dentistry at www.dhp.virginia.gov/dentistry.

- 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".

- Within approximately 10 business 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.

- 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 you Address of Record to be made available to the public, complete both sections with the same address.



Virginia Board of Dentistry
Virginia Department of Health Professions
9960 Mayland Drive, Suite 300
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APPLICATION FOR REINSTATEMENT OF 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.

I. GENERAL INFORMATION

Name: Last	First	Middle/Maiden		Suffix
Address of Record (Mailing Address)	City	State	Zip Code	Telephone Number
Public Disclosable Address	City	State	Zip Code	Telephone Number

Email Address:	Fax Number:
Date of Birth ________/_________/________________	**Social Security Number or Virginia DMV Control Number** ____ ____ ____--____ ____ --____ ____ ____ ____

License Number	Date of Expiration	Name at time of Original Licensure*

Please check the applicable box below:

☐ REINSTATEMENT REQUESTED DUE TO LAPSE OF LICENSE

☐ REINSTATEMENT REQUESTED DUE TO SUSPENSION

☐ REINSTATEMENT REQUESTED DUE TO REVOCATION

FOR OFFICE USE ONLY

FEE AMOUNT	APPLICANT NUMBER	DATE OF REINSTATEMENT

NOTE: 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 the by Department of Health Professions for identification and will not be disclosed for other purposes except as provided by law. Federal and state law requires this number be shared with other agencies for child support enforcement activities.

3. 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.	Have you ever been dropped, suspended, expelled or disciplined by any school or college for any cause whatever? If yes, give details, school(s); address and dates(s) on a separate page.	[ ] Yes	[ ] No
b.	Has your practice of dental hygiene since expiration of your license been in the Commonwealth of Virginia? Is yes, give location.________________________________	[ ] Yes	[ ] No
c.	Has any of your work since the expiration of your dental hygiene license been in any field other than the practice of dentistry? If yes, give details, jurisdictions(s) and date(s). ____________________ ____________________ ____________________	[ ] Yes	[ ] No
d.	Have you ever announced yourself, or held yourself out, as being a specialist in any branch of dentistry? If yes, give specialty and jurisdictions____________________ ____________________	[ ] Yes	[ ] No
e.	Have you ever been denied a license or the privilege of taking a dental hygiene licensure/competency examination by any licensing authority? If yes, give details, jurisdiction(s) and date(s).____________________ ____________________ ____________________	[ ] Yes	[ ] No
f.	List all jurisdictions in which you currently hold or have ever held a license/registration/certification to practice dental hygiene or as any other health care professional:		

Jurisdiction	License Number	Date Issued	Expiration Date
__________	__________	__________	__________
__________	__________	__________	__________
__________	__________	__________	__________
__________	__________	__________	__________

g	Have you ever failed the dental hygiene licensing examination given for another jurisdiction? If yes, give details, jurisdiction(s) and date(s).____________________ ____________________ ____________________	[ ] Yes	[ ] No
h.	Have you ever been convicted of a violation of or pled Nolo Contender 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
i.	Have you ever voluntarily surrendered your clinical privileges while under investigation, been censured or warned, or been requested to withdraw from the staff or any hospital, nursing	[ ] Yes	[ ] No

	home, other health care facility, or any health care provider? If yes, give details, jurisdiction(s) and date(s) on a separate page.		
j.	Have you ever voluntarily withdrawn from any professional society while under investigation? If yes, give details, jurisdiction(s) and date(s) on a separate page.	[ ] Yes	[ ] No
k.	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/revocation, or probation, or reprimand/cease and desist or monitoring or practice, or limitation placed on scheduled drugs? If yes give details, jurisdiction(s) and date(s) on a separate page.	[ ] Yes	[ ] No
l.	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
m.	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
n.	Is there now, or has there ever been, in any jurisdiction, a complaint pending against your professional conduct or competence as a dentist/dental hygienist? If yes, give details, jurisdiction(s) and date(s) on a separate page.	[ ] Yes	[ ] No
o.	Have you ever had any malpractice suits brought against you? If yes, give details, jurisdiction(s) and date(s) for each suit on a separate page, and provide a letter from your attorney explaining each case.	[ ] Yes	[ ] No
p.	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 summary of diagnosis, treatment and prognosis.	[ ] Yes	[ ] No
q.	Have you ever received treatment for, or been hospitalized for, a nervous, emotional or mental disorder? If yes, provide a letter of explanation from the treating professional(s), including summary of diagnosis, treatment and prognosis.	[ ] Yes	[ ] No
r.	Do you have a physical disability, disease, or diagnosis which could affect your performance of professional duties within the last five (5) years? 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 summary of diagnosis, treatment and prognosis.	[ ] Yes	[ ] No
s.	Have you ever been adjudged mentally incompetent, or been voluntarily or in voluntarily committed to a mental institution? If yes, give details, jurisdiction(s) and dates) on a separate page, and provide certified copies of all applicable court documents.	[ ] Yes	[ ] No
t.	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, 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

My commission expires on _________________________________.

____
Signature of Notary Public

SEAL

VIRGINIA BOARD OF DENTISTRY
9960 Mayland Drive, Suite 300
Henrico, VA 23233-1463

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; include teaching positions, internship, hospital affiliations, all periods of non-professional activity or employment, volunteer work, and all periods of unemployment.

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 Complete Address, and Telephone #**

COMMONWEALTH OF VIRGINIA
BOARD OF DENTISTRY
Department of Health Professions

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FORM C

CERTIFICATION OF DENTAL/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 Reinstatement of Dental Hygiene licensure in Virginia:

I, ____, was granted License Number ________________________

on __________________19_____20_____ 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: Please complete and return this form to the applicant. If disciplinary action has been taken, return the form to the Board of Dentistry.

State of __________________________________ Name of Licensee_______________________________________

Graduate of_______________________________ License #_____________________ Issued___________________

By [ ] Reciprocity [ ] Examination [ ] 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

NAME OF LICENSEE ______________________ LICENSE NUMBER ________________

CONTINUING EDUCATION COURSES

Complete all information and **include** all required supporting documents.

Pursuant to *18VAC60-25-190.B* of the **Regulations Governing the Practice of Dental Hygiene,** CE programs shall be clinical courses in dental or dental hygiene practice or supportive of clinical services. Courses not acceptable include, but are not limited to: estate planning, financial planning, investments, & personal health.

DATE	NAME OF COURSE	APPROVED SPONSOR	CE HOURS EARNED

TOTAL HOURS______________