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

APPLICATION REQUIREMENTS FOR THE FOLLOWING

Restricted Dental Volunteer License (§ 54.1-2712.1)
Restricted Dental Hygiene Volunteer License (§ 54.1-2726.1)

All required documentation is to be sent to the Board office in a single packet with the application. An incomplete application or submission of single parts or document delay the licensing process. A completed application must include the following:

____ 1. Application.

____ 2. Certified check, cashier's check or money order, made payable to the Treasurer of Virginia in the amount of $25.

____ 3. Form AA: If applicable, certification must be provided by the supervising dentists indicating he/she will review the quality of case rendered by the dentist/dental hygienists with the restricted volunteer license at least every thirty days.

____ 4. Form B: Chronology listing all activities since receiving degree, which must document at least five years of clinical practice.

____ 5. Form C: Certification of licensure not older than 6 months from each jurisdiction in which you have or ever held a license to practice dentistry. Copies of licenses or permits are not accepted. Certification is not required if you ever held a license in Virginia..\ Please list all states under Section "b" under Applicant History on page 2 of the application.

____ 6. Certify that you have not failed a clinical licensure examination within the last five years. Item "d" on page 3 of application.

____ 7. Application Affidavit which must be notarized and which authorizes the release of confidential information, affirms that your application is complete and correct, and attests that you have read and understand will remain current with the applicable Virginia dental and dental hygiene laws and regulations of the Virginia Board of Dentistry. In addition, no remuneration will be received directly or indirectly for dental/dental hygiene services. A passport-type photo not older than 6 months is required.

____ 8. Documentation must be provided to show each name change made since receiving your degree. Photocopies of marriage licenses or court orders are accepted.

_____ 9. Original, current reports, not older than 6 months, form the (1) Healthcare Integrity and Protection Data Bank (HIPDB) AND (2) National Practitioner Data Bank (NPDB) (Regulation 18 VAC 60-20-100 and should be submitted with the application. These two reports can be obtained from www.npdb-hipdb.hrsa.gov.,1-800- 767-6732, P. O. Box 10832, Chantilly, VA 20153-0832. Copies are not acceptable.

NOTES:

- 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.

- You may obtain the Virginia dental and dental hygiene laws and regulations of the Virginia Board of Dentistry on-line at www.dhp.virginia.gov/dentistry.

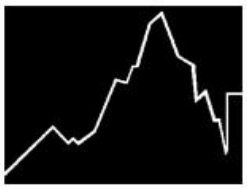
- To receive notice that your application has been delivered to the board, it is suggested that the complete packet be mailed by “Certified Mail-Return Receipt Requested” or with “Delivery Confirmation”.

- After 10 business days of applying, you might check on-line to see if your license has been issued by going to www.dhp.virgina.gov and selecting License Lookup.

- Applicants who submit an incomplete application will be notified within 10 business days of receipt that required information is missing.

- 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 updated/resubmitted before a license can be issued.

- Documents submitted with an application are the property of the board and cannot be returned.



Commonwealth of Virginia
Board of Dentistry
Department of Health Professions
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APPLICATION FOR RESTRICTED VOLUNTEER LICENSE TO PRACTICE DENTISTRY OR DENTAL HYGIENE

( ) DENTAL RESTRICTED VOLUNTEER LICENSE
( ) DENTAL HYGIENIST RESTRICTED VOLUNTEER 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 enclosed it with the application.

I. **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 Virginia DMV Control Number ____ ____ ____---____ ____---____ ____ ____ ____

Dental Specialty Graduate Date _____ _____ _____ Month Date Year	Specialty Degree Or Certificate	ADA-Coda Approved Dental School	City/State

FOR OFFICE USE ONLY

Date Received	Form AA	Form B	Form C –Certification of Licensure

_____National Practitioner Data Bank _____Healthcare Integrity and Protection Data Bank	

Fee	APPLICANT #	LICENSE #	DATE ISSUED

*Name change: Documentation must be provided to show name changes(s) if name has ever 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 Number or 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 required that this number be shared with other agencies for child support enforcement activities.

APPLICANT HISTORY

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

Months & Years	Name of Dental/Dental Hygiene School	Passed or Failed or Graduated
_____to _____	_____	_____
_____to_____	_____	_____

b. List all jurisdictions where you have been issued a license to practice dentistry/dental hygiene, active or inactive. Indicate license number and date issued.

Jurisdiction	License Number	Date Issued	State Active or Inactive
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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 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 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 dentistry, your DEA permit, 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 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

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

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 will not receive remuneration directly or indirectly for providing dental services.

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

SECURELY PASTE A PASSPORT-TYPE PHOTOGRAPH
IN THE BOX BELOW. NOTARY SEAL MUST OVERLAY THE PHOTOGRAPH.

NOTARY SEAL
MUST OVERLAY PHOTOGRAPH

Commonwealth of Virginia
BOARD OF DENTISTRY
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FORM AA

FOR DENTAL APPLICANTS: You may be required now or will be required in the future to have a sponsoring dentist in order to hold a restricted volunteer license. When you are required to have a sponsor is determined by your practice history as reported on FORM B: CHRONOLOGY and your answers below. You must have a sponsor if you have not been in active practice within the past five years of making application.

NAME OF APPLICANT: _____Dental Restricted Volunteer License

1. Name of address of clinic you will be volunteering at:
   _____

   _____

2. Are you still in active practice: Yes _____ No _____

3. If you answered no above, please give the month and year when you were last in active practice. Month _____ Year _____

4. How many years have passed since your last date of service: Calculate by subtracting the month and year reported above from the current month and year:
   Number of Months _____/Number of years _____

5. a. If your answer above is less than five years then you do not presently need a sponsor and you may stop here. The date when you must have a sponsor will be specified on your restricted volunteer license. It is your responsibility to obtain and report your sponsor by the date specified on your license. You may voluntarily obtain and report a sponsor with your application.

OR

   b. If your answer above is five years or greater then your sponsor must provide the information requested below.

TO BE COMPLETED BY SPONSOR

6. By affixing my signature below, I will review the quality of care rendered by the above named applicant at least every 30 days who will only treat patients who have been screened by the approved clinic and are eligible for treatment. I will directly observe patient care being provided and review all patient charts at least quarterly. Such supervision shall be noted in patient charts and maintained in accordance with 18 VAC 60-20-15.

_____
Signature of Sponsor

_____
Virginia License Number

COMMONWEALTH OF VIRGINIA
BOARD OF DENTISTRY

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.

Only applicants for dental **licensure by credentials** are required to provide the Number of Hours of Clinical Practice. You must report the number of hours you were engaged in clinical practice for each dental position you held within the six year period prior to submitting this application. Report multiple year positions as hours per calendar year, i.e. 600 hours in 2004 or 1000 hours each year for 200-2004.

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 #**	**Number of Hours of Clinical Practice**

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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 licensure in Virginia by:

[ ] Examination for Dental License
[ ] Examination for Dental Hygiene License
[ ] Reinstatement
[ ] Full Time Faculty
[ ] Credentials for Dental License
[ ] Endorsement for Dental Hygiene License
[ ] Teachers License
[ ] Registration for Volunteer Practice

I, _____, was granted License Number _____

on _____ by the State of _____. The Virginia Board of Dentistry
Month Date Year

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