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 REGISTRATION FOR VOLUNTEER DENTAL PRACTICE

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.

Pursuant to §54.2701.5 of the Code of Virginia and Regulation 18VAC60-21-230(E), the following documentation is required to submit an application for Registration for Volunteer Dental Practice:

____ 1. **Application:** Please be sure that all information and questions are completed on the application and submitted to board **at least 15 days prior** to engaging in such practice.

____ 2. **Registration Fee:** The fee for **a registration for volunteer practice is $10** 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. Applicants must hold a current, valid unrestricted license to practice dentistry.

____ 4. A copy of a current, valid unrestricted license to practice dentistry.

____ 5. The name of the nonprofit organization, date(s) and location(s). The complete address, including zip code, of the location(s) is required to complete your application.

____ 6. Completed Sponsor Certification for Volunteer Registration form.

____ 7. 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.

____ 8. **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.

____ 9. **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.
- 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.

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APPLICATION FOR REGISTRATION FOR VOLUNTEER DENTAL PRACTICE

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

Date of Birth _____/_____/_____ Month Day Year	**Social Security Number or Virginia DMV control Number**** ____ ____ ____---____ ____--____ ____ ____ ____

Address of record (Mailing Address)	City	State	Zip Code	Telephone Number

Email Address	Fax#

List all jurisdictions in which you currently hold or have ever held a license/registration/certification to practice as a dental hygienist or as another health care professional:

State	Profession	Number Issued	Issue Date	Expiration Date

Has your license to practice as a dentist or as any other health care professional in any state/jurisdiction ever been suspended or revoked? If yes, give details, jurisdiction(s) and date(s) on a separate page.

No _____ **Yes**_____

Date(s) of Volunteer Practice	**COMPLETE** Physical address of Volunteer Practice Location:

Name of Sponsoring Organization:

_____ Remote Area Medical (RAM)

_____ Other: Full name of organization: _____

ATTACH A COMPLETED CERTIFICATION FORM FROM THE SPONSORING ORGANIZATION

Have you ever been convicted of a violation or plead Nolo Contedere, to any federal, state or local statue, 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. **No** _____ **Yes** _____

I acknowledge that the licensure exemption sought through this application shall only be valid, in compliance with the Board's regulations, during the limited period that such free health care is made available through the volunteer, nonprofit organization on the dates and at the location filed with the Board.

SIGNATURE: _____ DATE:_____

***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.**

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SPONSOR CERTIFICATION FOR VOLUNTEER REGISTRATION

APPLICANT: THIS FORM IS TO BE COMPLETED BY A REPRESENTATIVE OF THE NONPROFIT ORGANIZATION SPONSORING YOUR VOLUNTEER PRACTICE.

PRINT CLEARLY OR TYPE:

I _____ certify that _____ is a publicly supported all volunteer, nonprofit organization that sponsors the provision of health care to populations of underserved people.

_____
Signature of Sponsor/Representative

_____
Title of Sponsor Representative

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