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 CERTIFICATION TO PERFORM COSMETIC PROCEDURES

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. You should know and understand the laws in Virginia regarding Certification to perform cosmetic procedures before completing the application. Read the provisions for certification, **Part VII, 18VAC60-21-350** through **18VAC60-21-400**.

In order for an oral and maxillofacial surgeon to perform aesthetic or cosmetic procedures, he shall be certified by the board pursuant to § 54.1-2709.1 of the Code. Such certification shall only entitle the licensee to perform procedures above the clavicle or within the head and neck region of the body based on the licensee's education, training, and experience, certification.

____ 1 Hold an active unrestricted dentist license from the Board.

____ 2. **Application:** Please be sure that all information and questions are completed on the application.

____ 3. **Application Fee:** The fee for a **Certification to Perform Cosmetic Procedures is $225** 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.

____ 4. **Original Transcript or Certification:** Graduation from an Oral and Maxillofacial Surgery residency program accredited by the Commission on Dental Accreditation (CODA).

____ 5. **ABOMS Documentation:** Documentation verifying current board certification by the American Board of Oral and Maxillofacial Surgery (ABOMS) **or** documentation verifying board eligibility as defined by ABOMS.

____ 6. **Current Hospital Privileges:** Documentation confirming current privileges on a hospital staff to perform oral and maxillofacial surgery.

____ 7. **Certification of Completion of Training:** For each procedure you are applying for certification to perform, check the requirement that applies to you and attach the appropriate documentation.

- If his oral and maxillofacial residency or cosmetic clinical fellowship was completed after July 1, 1996, and training in cosmetic surgery was a part of such residency or fellowship, submit:
  a. A letter from the director of the residency or fellowship program documenting the training received in the residency or in the clinical fellowship to substantiate adequate training in the specific procedures for which the applicant is seeking certification; and
  b. Documentation of having performed as primary or assistant surgeon at least 10 proctored cases in each of the procedures for which he seeks to be certified.

- If his oral and maxillofacial residency was completed prior to July 1, 1996, or if his oral and maxillofacial residency was completed after July 1, 1996, and training in cosmetic surgery was not a part of the applicant's residency, submit:
  a. Documentation of having completed didactic and clinically approved courses to include the dates attended, the location of the course, and a copy of the certificate of attendance. Courses shall provide sufficient training in the specific procedures requested for certification and shall be offered by:
     1. An advanced specialty education program in oral and maxillofacial surgery accredited by the Commission on Dental Accreditation;
     2. A medical school accredited by the Liaison Committee on Medical Education or other official accrediting body recognized by the American Medical Association;

3. The American Dental Association or one of its constituent and component societies or other ADA Continuing Education Recognized Programs (CERP) approved for continuing dental education; or
4. The American Medical Association approved for category 1, continuing medical education; and

b. Documentation of either:
1. Holding current privileges to perform cosmetic surgical procedures within a hospital accredited by the Joint Commission on Accreditation of Healthcare Organizations; or
2. Having completed at least 10 cases as primary or secondary surgeon in the specific procedures for which the applicant is seeking certification, of which at least five shall be proctored cases as defined in this chapter.

____ 8. 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.

____ 9. **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.

____ 10. **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. Failure to comply with legal requirements, failure to properly complete the application or failure to provide required documentation will result in the delay or denial of your application. Please check carefully to assure that all required information is provided with your application. It is your responsibility to maintain a copy of this application and all documents submitted to the Board or received from the Board for your future reference.

- 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 CERTIFICATION TO PERFORM COSMETIC PROCEDURES 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.

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#

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

Virginia Dental License Number:	Virginia Oral & Maxillofacial Surgical Practice Registration Number

Name of Practice (if applicable):

Check only one and attach a copy of documentation of American Board of Oral and Maxillofacial Surgery:

_____ Certification **OR** _____ Eligibility

Name of hospital where you currently hold privileges to perform oral and maxillofacial surgery: (Provide a copy of the letter confirming the privileges granted)

Certification is sought for : (check all that apply)

[ ] Rhinoplasty & other treatment of the nose;
[ ] Blepharoplasty & other treatment of the eyelid;
[ ] Rhytidectomy & other treatment of facial skin wrinkles & sagging;
[ ] Submental liposuction & other procedures to remove fat;
[ ] Browlift (either open or endoscopic technique) & other procedures to remove furrows & sagging skin on the upper eyelid & forehead;
[ ] Otoplasty & other procedures to change the appearance of the ear;
[ ] Laser resurfacing or dermabrasion & other procedures to remove facial skin irregularities;
[ ] Platysmal muscle plication & other procedures to correct the angle between the chin & neck;
[ ] Application of injectable medication or material for the purpose of treating extra-oral cosmetic conditions;

By signing below, I attest that I am the person referred to in the forgoing application and the attached supporting documents and certify that the information on this application and in the attachments is true, complete and correct to the best of my knowledge.

_____ Signature of applicant

_____ Date

APPLICANTS DO NOT USE SPACES BELOW THIS LINE – FOR OFFICE USE ONLY

***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.**

FEE AMOUNT	APPLICANT #	LICENSE #	DATE ISSUED

Name (Last, First, M.I., Suffix, Maiden Name)	**Virginia Dental License Number**

RHINOPLASTY AND OTHER TREATMENT OF THE NOSE:

Check the requirement that applies to you and attach the appropriate documentation:

_____ My residency program completion date is after July 1, 1996 and training in cosmetic procedures was part of the residency. I am attaching a letter from the program director documenting the training provided in rhinoplasty and other treatment of the nose and documentation from the program verifying that I performed as primary or assistant surgeon, at least 10 proctored cases in rhinoplasty and other treatment of the nose.

OR

_____ My residency program completion date is prior to July 1, 1996 **or** my residency program was completed after July 1, 1996 and did not include training in cosmetic procedures. I am attaching all of the following:

1) Documentation of having completed didactic and clinically approved courses specific to rhinoplasty and other treatment of the nose that includes the course title, dates attended, and the location of the course and, the certificate for each course listed. These documents confirm that the courses were obtained from an advanced specialty education program in oral and maxillofacial surgery accredited by the Commission on Dental Accreditation, a medical school accredited by the Liaison Committee on Medical Education or other official accrediting body recognized by the American Medical Association, the American Dental Association (ADA) or one of its constituent and component societies or other ADA Continuing Education Recognized Programs (CERP) approved for continuing dental education, or the American Medical Association, approved for category 1, continuing medical education.

AND

2) Documentation of current privileges to perform cosmetic surgical procedures within a hospital accredited by the Joint Commission on Accreditation of Healthcare Organizations, **or;**

   Documentation of having completed at least 10 cases as primary or secondary surgeon in rhinoplasty and other treatment of the nose of which at least 5 were proctored.

Name (Last, First, M.I., Suffix, Maiden Name)	**Virginia Dental License Number**

BLEPHAROPLASTY AND OTHER TREATMENT OF THE EYELID:

Check the requirement that applies to you and attach the appropriate documentation:

_____ My residency program completion date is after July 1, 1996 and training in cosmetic procedures was part of the residency. I am attaching a letter from the program director documenting the training provided in blepharoplasty and other treatment of the eyelid and documentation from the program verifying that I performed as primary or assistant surgeon, at least 10 proctored cases in blepharoplasty and other treatment of the eyelid.

OR

_____ My residency program completion date is prior to July 1, 1996 **or** my residency program was completed after July 1, 1996 and did not include training in cosmetic procedures. I am attaching all of the following:

1) Documentation of having completed didactic and clinically approved courses specific to blepharoplasty and other treatment of the eyelid that includes the course title, dates attended, and the location of the course and, the certificate for each course listed. These documents confirm that the courses were obtained from an advanced specialty education program in oral and maxillofacial surgery accredited by the Commission on Dental Accreditation, a medical school accredited by the Liaison Committee on Medical Education or other official accrediting body recognized by the American Medical Association, the American Dental Association (ADA) or one of its constituent and component societies or other ADA Continuing Education Recognized Programs (CERP) approved for continuing dental education, or the American Medical Association, approved for category 1, continuing medical education.

AND

2) Documentation of current privileges to perform cosmetic surgical procedures within a hospital accredited by the Joint Commission on Accreditation of Healthcare Organizations, **or;**

   Documentation of having completed at least 10 cases as primary or secondary surgeon in blepharoplasty and other treatment of the eyelid of which at least 5 were proctored.

Name (Last, First, M.I., Suffix, Maiden Name)	**Virginia Dental License Number**

RHYTIDECTOMY AND OTHER TREATMENT OF FACIAL SKIN WRINKLES AND SAGGING:

Check the requirement that applies to you and attach the appropriate documentation:

_____ My residency program completion date is after July 1, 1996 and training in cosmetic procedures was part of the residency. I am attaching a letter from the program director documenting the training provided in rhytidectomy and other treatment of facial skin wrinkles and sagging and documentation from the program verifying that I performed as primary or assistant surgeon, at least 10 proctored cases in rhytidectomy and other treatment of facial skin wrinkles and sagging.

OR

_____ My residency program completion date is prior to July 1, 1996 **or** my residency program was completed after July 1, 1996 and did not include training in cosmetic procedures. I am attaching all of the following:

1) Documentation of having completed didactic and clinically approved courses specific to rhytidectomy and other treatment of facial skin wrinkles and sagging that includes the course title, dates attended, and the location of the course and, the certificate for each course listed. These documents confirm that the courses were obtained from an advanced specialty education program in oral and maxillofacial surgery accredited by the Commission on Dental Accreditation, a medical school accredited by the Liaison Committee on Medical Education or other official accrediting body recognized by the American Medical Association, the American Dental Association (ADA) or one of its constituent and component societies or other ADA Continuing Education Recognized Programs (CERP) approved for continuing dental education, or the American Medical Association, approved for category 1, continuing medical education.

AND

2) Documentation of current privileges to perform cosmetic surgical procedures within a hospital accredited by the Joint Commission on Accreditation of Healthcare Organizations, **or;**

   Documentation of having completed at least 10 cases as primary or secondary surgeon in rhytidectomy and other treatment of facial skin wrinkles and sagging of which at least 5 were proctored.

Name (Last, First, M.I., Suffix, Maiden Name)	**Virginia Dental License Number**

SUBMENTAL LIPOSUCTION AND OTHER PROCEDURES TO REMOVE FAT:

Check the requirement that applies to you and attach the appropriate documentation:

_____ My residency program completion date is after July 1, 1996 and training in cosmetic procedures was part of the residency. I am attaching a letter from the program director documenting the training provided in submental liposuction and other procedures to remove fat and documentation from the program verifying that I performed as primary or assistant surgeon, at least 10 proctored cases in submental liposuction and other procedures to remove fat.

OR

_____ My residency program completion date is prior to July 1, 1996 **or** my residency program was completed after July 1, 1996 and did not include training in cosmetic procedures. I am attaching all of the following:

1) Documentation of having completed didactic and clinically approved courses specific to submental liposuction and other procedures to remove fat that includes the course title, dates attended, and the location of the course and, the certificate for each course listed. These documents confirm that the courses were obtained from an advanced specialty education program in oral and maxillofacial surgery accredited by the Commission on Dental Accreditation, a medical school accredited by the Liaison Committee on Medical Education or other official accrediting body recognized by the American Medical Association, the American Dental Association (ADA) or one of its constituent and component societies or other ADA Continuing Education Recognized Programs (CERP) approved for continuing dental education, or the American Medical Association, approved for category 1, continuing medical education.

AND

2) Documentation of current privileges to perform cosmetic surgical procedures within a hospital accredited by the Joint Commission on Accreditation of Healthcare Organizations, **or;**

   Documentation of having completed at least 10 cases as primary or secondary surgeon in submental liposuction and other procedures to remove fat of which at least 5 were proctored.

Name (Last, First, M.I., Suffix, Maiden Name)	Virginia Dental License Number

BROWLIFT (EITHER OPEN OR ENDOSCOPIC TECHNIQUE) AND OTHER PROCEDURES TO REMOVE FURROWS AND SAGGING SKIN ON THE UPPER EYELID OR FOREHEAD:

Check the requirement that applies to you and attach the appropriate documentation:

_____ My residency program completion date is after July 1, 1996 and training in cosmetic procedures was part of the residency. I am attaching a letter from the program director documenting the training provided in browlift (either open or endoscopic technique) and other procedures to remove furrows and sagging skin on the upper eyelid or forehead and documentation from the program verifying that I performed as primary or assistant surgeon, at least 10 proctored cases in in browlift (either open or endoscopic technique) and other procedures to remove furrows and sagging skin on the upper eyelid or forehead.

OR

_____ My residency program completion date is prior to July 1, 1996 **or** my residency program was completed after July 1, 1996 and did not include training in cosmetic procedures. I am attaching all of the following:

1) Documentation of having completed didactic and clinically approved courses specific to browlift (either open or endoscopic technique) and other procedures to remove furrows and sagging skin on the upper eyelid or forehead that includes the course title, dates attended, and the location of the course and, the certificate for each course listed. These documents confirm that the courses were obtained from an advanced specialty education program in oral and maxillofacial surgery accredited by the Commission on Dental Accreditation, a medical school accredited by the Liaison Committee on Medical Education or other official accrediting body recognized by the American Medical Association, the American Dental Association (ADA) or one of its constituent and component societies or other ADA Continuing Education Recognized Programs (CERP) approved for continuing dental education, or the American Medical Association, approved for category 1, continuing medical education.

AND

2) Documentation of current privileges to perform cosmetic surgical procedures within a hospital accredited by the Joint Commission on Accreditation of Healthcare Organizations, **or;**

   Documentation of having completed at least 10 cases as primary or secondary surgeon in browlift (either open or endoscopic technique) and other procedures to remove furrows and sagging skin on the upper eyelid or forehead of which at least 5 were proctored.

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OTOPLASTY AND OTHER PROCEDURES TO CHANGE THE APPEARANCE OF THE EAR:

Check the requirement that applies to you and attach the appropriate documentation:

_____ My residency program completion date is after July 1, 1996 and training in cosmetic procedures was part of the residency. I am attaching a letter from the program director documenting the training provided in Otoplasty and other procedures to change the appearance of the ear and documentation from the program verifying that I performed as primary or assistant surgeon, at least 10 proctored cases in Otoplasty and other procedures to change the appearance of the ear.

OR

_____ My residency program completion date is prior to July 1, 1996 **or** my residency program was completed after July 1, 1996 and did not include training in cosmetic procedures. I am attaching all of the following:

1) Documentation of having completed didactic and clinically approved courses specific to Otoplasty and other procedures to change the appearance of the ear that includes the course title, dates attended, and the location of the course and, the certificate for each course listed. These documents confirm that the courses were obtained from an advanced specialty education program in oral and maxillofacial surgery accredited by the Commission on Dental Accreditation, a medical school accredited by the Liaison Committee on Medical Education or other official accrediting body recognized by the American Medical Association, the American Dental Association (ADA) or one of its constituent and component societies or other ADA Continuing Education Recognized Programs (CERP) approved for continuing dental education, or the American Medical Association, approved for category 1, continuing medical education.

AND

2) Documentation of current privileges to perform cosmetic surgical procedures within a hospital accredited by the Joint Commission on Accreditation of Healthcare Organizations, **or;**

   Documentation of having completed at least 10 cases as primary or secondary surgeon in Otoplasty and other procedures to change the appearance of the ear, of which at least 5 were proctored.

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LASER RESURFACING OR DERMABRASION AND OTHER PROCEDURES TO REMOVE FACIAL SKIN IRREGULARITIES:

Check the requirement that applies to you and attach the appropriate documentation:

_____ My residency program completion date is after July 1, 1996 and training in cosmetic procedures was part of the residency. I am attaching a letter from the program director documenting the training provided in laser resurfacing or dermabrasion and other procedures to remove facial skin irregularities and documentation from the program verifying that I performed as primary or assistant surgeon, at least 10 proctored cases in laser resurfacing or dermabrasion and other procedures to remove facial skin irregularities.

OR

_____ My residency program completion date is prior to July 1, 1996 **or** my residency program was completed after July 1, 1996 and did not include training in cosmetic procedures. I am attaching all of the following:

1) Documentation of having completed didactic and clinically approved courses specific to laser resurfacing or dermabrasion and other procedures to remove facial skin irregularities that includes the course title, dates attended, and the location of the course and, the certificate for each course listed. These documents confirm that the courses were obtained from an advanced specialty education program in oral and maxillofacial surgery accredited by the Commission on Dental Accreditation, a medical school accredited by the Liaison Committee on Medical Education or other official accrediting body recognized by the American Medical Association, the American Dental Association (ADA) or one of its constituent and component societies or other ADA Continuing Education Recognized Programs (CERP) approved for continuing dental education, or the American Medical Association, approved for category 1, continuing medical education.

AND

2) Documentation of current privileges to perform cosmetic surgical procedures within a hospital accredited by the Joint Commission on Accreditation of Healthcare Organizations, **or;**

   Documentation of having completed at least 10 cases as primary or secondary surgeon in laser resurfacing or dermabrasion and other procedures to remove facial skin irregularities, of which at least 5 were proctored.

Name (Last, First, M.I., Suffix, Maiden Name)	Virginia Dental License Number

PLATYSMAL MUSCLE PLICATION AND OTHER PROCEDURES TO CORRECT THE ANGLE BETWEEN THE CHIN AND NECK:

Check the requirement that applies to you and attach the appropriate documentation:

_____ My residency program completion date is after July 1, 1996 and training in cosmetic procedures was part of the residency. I am attaching a letter from the program director documenting the training provided in Platysmal muscle plication and other procedures to correct the angle between the chin and neck, and documentation from the program verifying that I performed as primary or assistant surgeon, at least 10 proctored cases in Platysmal muscle plication and other procedures to correct the angle between the chin and neck.

OR

_____ My residency program completion date is prior to July 1, 1996 **or** my residency program was completed after July 1, 1996 and did not include training in cosmetic procedures. I am attaching all of the following:

1) Documentation of having completed didactic and clinically approved courses specific to Platysmal muscle plication and other procedures to correct the angle between the chin and neck that includes the course title, dates attended, and the location of the course and, the certificate for each course listed. These documents confirm that the courses were obtained from an advanced specialty education program in oral and maxillofacial surgery accredited by the Commission on Dental Accreditation, a medical school accredited by the Liaison Committee on Medical Education or other official accrediting body recognized by the American Medical Association, the American Dental Association (ADA) or one of its constituent and component societies or other ADA Continuing Education Recognized Programs (CERP) approved for continuing dental education, or the American Medical Association, approved for category 1, continuing medical education.

AND

2) Documentation of current privileges to perform cosmetic surgical procedures within a hospital accredited by the Joint Commission on Accreditation of Healthcare Organizations, **or;**

   Documentation of having completed at least 10 cases as primary or secondary surgeon in Platysmal muscle plication and other procedures to correct the angle between the chin and neck, of which at least 5 were proctored.

Name (Last, First, M.I., Suffix, Maiden Name)	**Virginia Dental License Number**

APPLICATION OF INJECTABLE MEDICATION OR MATERIAL FOR THE PURPOSE OF TREATING EXTRA-ORAL COSMETIC CONDITIONS:

Check the requirement that applies to you and attach the appropriate documentation:

_____ My residency program completion date is after July 1, 1996 and training in cosmetic procedures was part of the residency. I am attaching a letter from the program director documenting the training provided in application of injectable medication or material for the purpose of treating extra-oral cosmetic conditions, and documentation from the program verifying that I performed as primary or assistant surgeon, at least 10 proctored cases in application of injectable medication or material for the purpose of treating extra-oral cosmetic conditions.

OR

_____ My residency program completion date is prior to July 1, 1996 **or** my residency program was completed after July 1, 1996 and did not include training in cosmetic procedures. I am attaching all of the following:

1) Documentation of having completed didactic and clinically approved courses specific to application of injectable medication or material for the purpose of treating extra-oral cosmetic conditions that includes the course title, dates attended, and the location of the course and, the certificate for each course listed. These documents confirm that the courses were obtained from an advanced specialty education program in oral and maxillofacial surgery accredited by the Commission on Dental Accreditation, a medical school accredited by the Liaison Committee on Medical Education or other official accrediting body recognized by the American Medical Association, the American Dental Association (ADA) or one of its constituent and component societies or other ADA Continuing Education Recognized Programs (CERP) approved for continuing dental education, or the American Medical Association, approved for category 1, continuing medical education.

AND

2) Documentation of current privileges to perform cosmetic surgical procedures within a hospital accredited by the Joint Commission on Accreditation of Healthcare Organizations, **or;**

   Documentation of having completed at least 10 cases as primary or secondary surgeon in application of injectable medication or material for the purpose of treating extra-oral cosmetic conditions, of which at least 5 were proctored.