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 RESTRICTED VOLUNTEER DENTAL LICENSE

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

____ 2. **Application Fee:** The fee for a **restricted volunteer dental license by examination is $25** 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. **Form A:** If applicable, certification must be provided by the supervising dentist indicating he/she will review the quality of care rendered by the dentist with the restricted volunteer license at least every thirty days pursuant to 18VAC60-21-230.D(3).

____ 4. **Form B: Chronology** List **ALL** activities, personal and professional, to include all time periods of employment and unemployment, since receiving your doctoral degree or post-doctoral advanced certification. *(Resumes and curriculum vitae are not accepted as substitutes for completing the chronological listing on Form B and will not be considered.)*

____ 5. **Form C: Original** licensure status and certification from every jurisdiction in which you currently hold or have ever held a license/registration/certification to practice as a dentist or as another health care professional. Copies of permits are not accepted. Certifications cannot be older than 6 months from date prepared.

____ 6. **Original NPDB:** A current report, not older than 6 months from date prepared, must be obtained by Self Query from the National Practitioner Data Bank (NPDB), which may be requested through their website at www.npdb.hrsa.gov. There is a fee for this report. ***This report from NPDB is required from all applicants, without exception*** *(Regulation 18VAC60-21-190.3)*.

____ 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:

- **A person holding a restricted volunteer dental license shall only practice in a public health or community free clinic that provides dental services to populations of undeserved people and only treat patients who have been screened by the approved clinic and are eligible for treatment.**
- Completed applications cannot be accessed or edited once they have been submitted.
- If your Virginia License is not issued within 6 months of the date of the NPDB (National Practitioner Databank) Self Query Report and certification of state licensure, you will be asked to submit a current NPDB Self Query Report and current state licensure certification before your application can be reviewed.
- **DEA Registration**: Applicants must have a dental license prior to applying for a DEA License. Requests for an application in Virginia should be made to the following: Drug Enforcement Administration, Attn: Registration Section/ODR, P.O. Box 2639, Springfield, VA 22152-2639; 1-800-882-9539; www.deadiversion.usdoj.gov
- 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.

Pursuant to Regulation 18VAC60-21-230.E. Qualifications for a restricted license.
Restricted volunteer license.

1. In accordance with § 54.1-2712.1 of the Code, the board may issue a restricted volunteer license to a dentist who:
   a. Held an unrestricted license in Virginia or another U.S. jurisdiction as a licensee in good standing at the time the license expired or became inactive;
   b. Is volunteering for a public health or community free clinic that provides dental services to populations of underserved people;
   c. Has fulfilled the board's requirement related to knowledge of the laws and regulations governing the practice of dentistry in Virginia;
   d. Has not failed a clinical examination within the past five years; and
   e. Has had at least five years of clinical practice.
2. A person holding a restricted volunteer license under this section shall:
   a. Only practice in public health or community free clinics that provide dental services to underserved populations;
   b. Only treat patients who have been screened by the approved clinic and are eligible for treatment;
   c. Attest on a form provided by the board that he will not receive remuneration directly or indirectly for providing dental services; and
   d. Not be required to complete continuing education in order to renew such a license.
3. The restricted volunteer license shall specify whether supervision is required, and if not, the date by which it will be required. If a dentist with a restricted volunteer license issued under this section has not held an active, unrestricted license and been engaged in active practice within the past five years, he shall only practice dentistry and perform dental procedures if a dentist with an unrestricted Virginia license, volunteering at the clinic, reviews the quality of care rendered by the dentist with the restricted volunteer license at least every 30 days. If supervision is required, the supervising dentist shall directly observe patient care being provided by the restricted volunteer dentist and review all patient charts at least quarterly. Such supervision shall be noted in patient charts and maintained in accordance with 18VAC60-21-90.
4. A restricted volunteer license granted pursuant to this section shall expire on June 30 of the second year after its issuance or shall terminate when the supervising dentist withdraws his sponsorship.
5. A dentist holding a restricted volunteer license issued pursuant to this section is subject to the provisions of this chapter and the disciplinary regulations that apply to all licensees practicing in Virginia.

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

APPLICATION FOR RESTRICTED VOLUNTEER DENTAL LICENSE 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#

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

DDS/DMD GRADUATION DATE	PROFESSIONAL DEGREE	CODA/CDAC APPROVED DENTAL SCHOOL/CITY/STATE
_____ _____ _____ Month Day Year		
RESIDENCY/SPECIALTY GRADUATION DATE	RESIDENCY/SPECIALTY DEGREE or CERTIFICATE	CODA/CDAC APPROVED DENTAL SCHOOL/CITY/STATE
_____ _____ _____ Month Day Year		

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

DATE RECEIVED	CERTIFICATION (SUPERVISOR) (FORM A)	CHRONOLOGY (FORM B)
CERTIFICATION (LICENSE FROM OTHER STATES) (FORM C OR LETTER)		NATIONAL PRACTITIONER DATA BANK

***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 #	RESTRICTED VOLUNTEER LICENSE #	DATE ISSUED

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. List in chronological order including months and years, the dental school(s) attended (include specialty and advanced programs):

Months & Years	Name of Dental School (ADA-CODA)	Passed/Failed
_____ to _____	_____	_____
_____ to _____	_____	_____
_____ to _____	_____	_____

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

Jurisdiction	Number	Type	Date Issued	Exp. Date
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

5. 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

_____

_____

6. Have you ever been convicted of a violation or plead Nolo Contendere, 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). [ ] Yes [ ] No

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.

_____

_____

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. [ ] Yes [ ] No

   _____

   _____

2. A. Within the past five years, have you been disciplined by any entity? [ ] Yes [ ] No
   If "YES" please provide a full explanation and any associated orders or letters from the entity.

   _____

   _____

   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 from the entity. [ ] 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 five years, have any conditions or restrictions been imposed upon you or your practice to avoid disciplinary action by any entity? If "YES", please provide a full explanation and any associated orders or letters from the entity. **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. _____ _____	[ ] 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/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 _____.

SEAL

_____
Signature of Notary Public

_____
Print Name

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

FORM A
CERTIFICATION OF DENTAL SUPERVISOR

INSTRUCTIONS: 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. You must have a sponsor if you have not been in active practice within the past five years of making application.

TO BE COMPLETED BY APPLICANT:

NAME OF APPLICANT: _____for Dental Restricted Volunteer License

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

   _____

2. Please give the month and year when you were last in active practice.
   Month _____ Year _____

3. How many years have passed since your last date of service: _____

4. **a**. If your answer above is less than five years, 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.

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

TO BE COMPLETED BY SPONSOR:

By affixing my signature below, I verify that 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 18VAC60-21-90 as required by 18VAC60-21-230.D(3)

_____
Signature of Sponsor

_____
Print Name

_____
Title

_____
Virginia License Number

_____
Date

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

FORM B
CHRONOLOGY

APPLICANT NAME:_____

Every applicant must provide a complete chronological, personal and professional history of all activities you have engaged in since receiving your degree or certification, including teaching positions, all periods of non-professional activity or employment, volunteer work and all periods of unemployment. **Curriculum vitae and resumes are not accepted as substitutes for completing the chronological listing and will not be considered.**

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 #**

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

FORM C
CERTIFICATION OF DENTAL 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
[ ] Credentials for Dental License
[ ] Dental Faculty License
[ ] Dental Temporary Permit
[ ] Examination for Dental Hygiene License
[ ] Credentials for Dental Hygiene License
[ ] Dental Hygiene Faculty License
[ ] Dental Hygiene Temporary Permit
[ ] Dental Restricted Volunteer License
[ ] Dental Hygiene Restricted Volunteer License
[ ] Dental Reinstatement
[ ] Dental Hygiene Reinstatement

I, was granted License Number _____, on _____ by the State of
Month Date Year.

_____. The Virginia Board of Dentistry requires that I submit evidence of the status of my license. You are hereby authorized to release any information in your files, favorable or otherwise directly to the **Virginia Board of Dentistry** at **9960 Mayland Drive, Suite 300, Henrico, Virginia 23233** or **denbd@dhp.virginia.gov**. Your early attention is appreciated.

_____ _____ _____
Applicant's Signature Applicant's Typed/Printed Name Applicant's Address

_____

Executive Officer of the Board: please send this form directly to the Virginia Board of Dentistry.

State of _____ Name of Licensee_____

Graduate of_____ License #_____Issued_____

By: [ ] Examination* [ ] Credentials [ ] Reciprocity with the State of _____ [ ] Endorsement with the State of _____

*If licensed by a state administered examination, please provide a score card or report which shows that testing included live patients.

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):_____

_____

_____

Comments, if any:_____

_____

SEAL

_____ _____ _____
Signature Title Date

_____
Print Name