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

# Application Requirements 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 are kept for one year.

_____ **1**.**Application:** Please be sure that all information and questions are completed on the application.

_____ **2**.**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 18VAC60-25-30(F), all fees are non-refundable. Your application will not be reviewed until you have submitted payment.

_____ **3**.**Original** certification of graduation from an Oral and Maxillofacial Surgery residency program accredited by the Commission on Dental Accreditation (CODA)

_____ **4.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.

_____ **5.Current Hospital Privileges:** documentation confirming current privileges on a hospital staff to perform oral and maxillofacial surgery.

_____ **6.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.

**NOTES:**

- 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**.

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

**VIRGINIA BOARD OF DENTISTRY**
**9960 Mayland Drive, Suite 300**
**Richmond, VA 23233-1463**
**(804) 367-4538**
**www.dhp.virginia.gov/dentistry**

# APPLICATION FOR CERTIFICATION TO PERFORM COSMETIC PROCEDURES

**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.

| 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# |
|---|---|
| | |
| Date of Birth<br>____ ___/____ ____/____ ___ ___ ___ | **Social Security Number or Virginia DMV Control Number**<br>____ ___ ___ -____ ___ -____ ____ ____ ____ |
| Virginia Dental License Number: | Virginia Oral and Maxillofacial Surgical Practice Registration Number: |

Name of Practice (if applicable):

**Check only one and <u>attach a copy of documentation of American Board of Oral and Maxillofacial Surgery:</u>**

_____ 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 and other treatment of the nose;
- [ ] Blepharoplasty and other treatment of the eyelid;
- [ ] Rhytidectomy and other treatment of facial skin wrinkles and sagging;
- [ ] Submental liposuction and other procedures to remove fat;
- [ ] Browlift (either open or endoscopic technique) and other procedures to remove furrows and sagging skin on the upper eyelid and forehead;
- [ ] Otoplasty and other procedures to change the appearance of the ear;
- [ ] Laser resurfacing or dermabrasion and other procedures to remove facial skin irregularities;
- [ ] Platysmal muscle plication and other procedures to correct the angle between the chin and 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

## DO NOT USE SPACES BELOW THIS LINE: FOR OFFICE USE ONLY

| Date Received | Fee | Pending # | Certification # | Date Issued |
|---|---|---|---|---|
| | | | | |

# RHINOPLASTY AND OTHER TREATMENT OF THE NOSE

| 1. Name (Last, First, M.I., Suffix, Maiden Name) | 2. Virginia Dental License Number: |
|---|---|

3. 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.

# BLEPHAROPLASTY AND OTHER TREATMENT OF THE EYELID

| 1. Name (Last, First, M.I., Suffix, Maiden Name) | 2. Virginia Dental License Number: |
|---|---|

3. 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.

# RHYTIDECTOMY AND OTHER TREATMENT OF FACIAL SKIN WRINKLES AND SAGGING

| 1. Name (Last, First, M.I., Suffix, Maiden Name) | 2. Virginia Dental License Number: |
|---|---|

3. 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.

# SUBMENTAL LIPOSUCTION AND OTHER PROCEDURES TO REMOVE FAT

| 1. Name (Last, First, M.I., Suffix, Maiden Name) | 2. Virginia Dental License Number: |
|---|---|

3. 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.

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

| 1. Name (Last, First, M.I., Suffix, Maiden Name) | 2. Virginia Dental License Number: |
|---|---|

3. 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.

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

| 1. Name (Last, First, M.I., Suffix, Maiden Name) | 2. Virginia Dental License Number: |
|---|---|

3. 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.

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

| 1. Name (Last, First, M.I., Suffix, Maiden Name) | 2. Virginia Dental License Number: |
|---|---|

3. 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.

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

| 1. Name (Last, First, M.I., Suffix, Maiden Name) | 2. Virginia Dental License Number: |
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3. 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.

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

| 1. Name (Last, First, M.I., Suffix, Maiden Name) | 2. Virginia Dental License Number: |
|---|---|
| | |

3. 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.

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