COMMONWEALTH OF VIRGINIA
DEPARTMENT OF HEALTH PROFESSIONS
BOARD OF DENTISTRY
9960 MAYLAND DRIVE, Suite 300
HENRICO, VIRGINIA 23233-1463
(804) 367-4538 www.dhp.virginia.gov/dentistry

INSTRUCTIONS FOR APPLICATION FOR REGISTRATION FOR DENTAL HYGIENE VOLUNTEER 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 are kept for one year.

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

___ **Application Fee**: The fee for a **Voluntary Permit to Practice Dental Hygiene is $10** and must be paid with a certified check, cashier's check or money order, made payable to **The Treasurer of Virginia**. Pursuant to 18VAC60-25-30(F) all fees are non-refundable. Your application will not be submitted to the Board of Dentistry for review until you have submitted payment

___ Provide a copy of a current, active license or certificate to practice dental hygiene.

___ Provide the name of the nonprofit organization that is sponsoring the provision of health care, the dates and the name and **complete** address of the location of the voluntary provision of services.

___ Completed Sponsor Certification for Volunteer Registration form.

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Department of Health Professions – Board of Dentistry
9960 Mayland Drive, Suite 300
Henrico, VA 23233-1463
Phone : 804-367-4538 FAX : 804-527-4428
www.dhp.virginia.gov

APPLICATION FOR REGISTRATION FOR DENTAL HYGIENE VOLUNTEER 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.

Name: Last	First:	Middle/Maiden	Suffix:

Date of Birth: _____/_____/______

Social Security Number OR Virginia DMV Control Number:

Mailing Address (Street and/or Box Number, City, State, Zip Code)

Telephone Number:

Email address:

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.

Jurisdiction	License Number	Date Issued	Expiration Date
________________	________________	________________	________________
________________	________________	________________	________________
________________	________________	________________	________________
________________	________________	________________	________________

Has your license to practice as a dental hygienist 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)

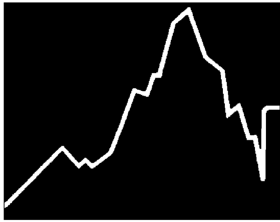
________ Other: Full name of organization: ____

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 of Applicant

_________________________________ Date



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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 this __________date of ___________________, _______.
Date Month Year

My Commission expires on ______________________.

____
Signature of Notary Public