Commonwealth of Virginia
BOARD OF DENTISTRY
Department of Health Professions
9960 Mayland Drive, Suite Suite 300
Henrico, VA 23233-1463
www.dhp.virginia.gov/dentistry (804) 367-4538 denbd@dhp.virginia.gov

APPLICATION FOR REGISTRATION TO PRACTICE AS A DENTAL ASSISTANT II

Check the box that applies: [ ] applying by education pursuant to 18VAC60-20-61
[ ] applying by endorsement pursuant to 18VAC60-20-72

Type or print clearly. Complete all sections. If the space provided for any section is insufficient, submit information on a separate page. Enclosed the $100 application Fee as a certified check, cashier's check or money order, made payable to the Treasurer of Virginia. Pursuant to 18VAC60-20-40 fees are non-refundable. A $35 processing fee will be charged for any check or money order returned unpaid.

Name: Last*	First	Middle/Maiden	Suffix

Address of record (Mailing Address)	City	State	Zip	Telephone Number
Public Disclosable Address	City	State	Zip	Telephone Number

E-mail Address	Fax#
Date of Birth _____/_____/_____	Social Security Number or Virginia DMV control Number* ____ ____ ____--____ ____ --____ ____ ____ ____

Graduation Date	Dental Assisting Expanded Duties Program/School: Name: Address: Telephone number:

Print Name as you wish it to appear on your registration	Place of Birth

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

Date received	Exam		
Fee	Applicant #		
License	Date Issued		

***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 or identification and will not be disclosed for other purposes except as provided for by law. Federal and state law requires that this number be shared with other agencies for child support enforcement activities.**

Dental Assisting National Board (DANB) Certification as a Certified Dental Assistant

Certification Number: _____ **Date Issued:** _____ **Expiration Date:** _____

List all jurisdictions in which you are or have been registered as a dental assistant.

Jurisdiction	License Number	Date Issued	Date Expired
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

I declare and certify under penalty of perjury that all answers given and all statements made in this application are true and correct. I hereby agree that furnishing any false information in this application constitutes cause for the denial, suspension, or revocation of registration to practice in the Commonwealth of Virginia. Further, I have carefully read the laws and regulations applicable to the practice of dentistry, dental hygiene and dental assisting. I hereby agree to abide by and remain current with the applicable laws and regulations which are available online at www.dhp.virginia.gov/dentistry**.**

_____ _____

Signature of Applicant **Date**