

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

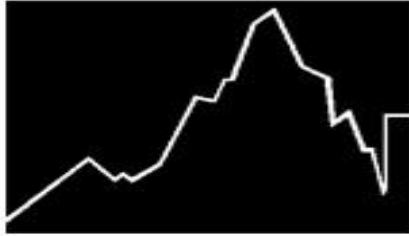
INSTRUCTIONS FOR APPLICATION FOR REACTIVATION OF DENTAL ASSISTANT II REGISTRATION

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 then destroyed.

- _____ **1.Application:** Please be sure that all information and questions are completed on the application. The application can be used for one year from date of receipt.
- _____ **2.Application Fee:** The fee to reactivate a **Dental Assistant II Registration is \$50** which 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 18VAC60-30-30(F), all fees are non-refundable. Your application will not be reviewed until you have submitted your payment.
- _____ **3.Evidence of a current credential as a **Certified Dental Assistant (CDA)**** conferred by the Dental National Board (DANB) or another certification from a credentialing organization recognized by the American Dental Association and acceptable to the board.
- _____ **4.Evidence of Continuing Clinical Competence:** The applicant must include documentation in the application sufficient to demonstrate continuing clinical competence in the duties for which the applicant is requesting reactivation of, which may include documentation of active practice in another state or in federal service, or a refresher course offered by an educational program accredited by the Commission on Dental Accreditation of the American Dental Association.
- _____ **5.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 and understand and will remain current with the laws and regulations governing the practice of dentistry in Virginia.**

Notes:

- **PLEASE NOTE:** If your Virginia Registration is not reactivated within six months of the Board's receipt of parts of the application, certain portions of the application may need to be resubmitted before your application can be reviewed.
- You might obtain the Virginia laws and the regulations governing the practice of dental assistants at www.dhp.virginia.gov/dentistry.
- To receive notice that your application has been delivered to the Board, it is suggested that the documents be mailed by "Certified Mail-Return Receipt Requested" or with "Delivery Confirmation".
- Within approximately 10 business days of receipt of an application, applicants will be notified of missing application items. Review of completed applications for licensure by credentials may take another 5 to 20 business days.
- Documents submitted with an application are the property of the board and cannot be returned.
- Consistent with Virginia law §54.1.2400.02 and mission of the Department of Health Professions, addresses of health professionals 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. .



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Virginia Department of Health Professions
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APPLICATION FOR REACTIVATION OF DENTAL ASSISTANT II REGISTRATION

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
E-Mail Address			Fax #		
Date of Birth ____/____/____		Social Security Number or <u>Virginia</u> DMV control Number* ____-____-____			
Virginia DAII Registration Number		Date Inactive Status Taken:	Date of Last Active Practice		
Name at Time of Original Licensure (Last, First, Maiden)					
Reactivation of Registration is sought for (check all that apply): <input type="checkbox"/> 1. Performing pulp capping procedures <input type="checkbox"/> 2. Packing and carving of amalgam restorations; <input type="checkbox"/> 3. Placing and shaping composite resin restorations with a slow speed hand piece; <input type="checkbox"/> 4. Taking final impressions; <input type="checkbox"/> 5. Use of a non-epinephrine retraction cord; <input type="checkbox"/> 6. Final cementation of crowns and bridges after adjustment and fitting by the dentist.					
*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/registered in other jurisdictions.**In accordance with § 54.1-116 of the <i>Code of Virginia</i> , you are required to submit your Social Security Number or your control number issued by the <u>Virginia Department of Motor Vehicles</u> . 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.					

FOR OFFICE USE ONLY

Fee Amount	Registration Number	Date License Reactivated
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ALL QUESTIONS MUST BE ANSWERED. If any of the following questions are answered "YES", you must explain and substantiate with documentation.

1. Has your practice ever been the subject of an investigation by any licensing authority?
Yes _____ No _____

If yes, you must provide an explanation and include jurisdiction(s) and date(s), unless you provided this information on your previous application.

2. Have you ever been denied a license, registration or certification in a health related field or jurisdiction? Yes _____ No _____

3. Is your license/registration in good standing in all jurisdictions where licensed?
Yes _____ No _____

4. Have you ever been convicted of a violation or pled Nolo Contendere to any federal, state or local statute, regulation or ordinance, or entered into any pleas bargaining relating to a felony or misdemeanor? (Excluding traffic violation, except convictions for driving under the influence)? Yes _____ No _____

If yes, you must provide an explanation and include an original copy of the disposition/record, certified by the Clerk of the Court, unless you provided this information on your previous application.

5. Do you have a physical disability, disease or diagnosis which could affect your performance or professional duties? Yes _____ No _____

If yes, provide an explanation and submit a letter from any treating professional(s) summarizing diagnosis, treatment and prognosis, unless you provided this information on your previous application.

6. Have you, within the last two (2) years, received treatment for, or been hospitalized for a nervous, emotional or mental disorder? Yes _____ No _____

If yes, you must provide a letter of explanation from the treating professional(s), including summary of diagnosis, treatment & prognosis, unless you provided this information on your previous application.

7. Did you relocate with a spouse who is the subject of a military transfer to the Commonwealth of Virginia? 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 assistants. I hereby agree to abide by and remain current with the applicable laws and regulations which are available on www.dhp.virginia.gov, 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 _____.

Signature of Notary Public