# VIRGINIA BOARD OF DENTISTRY

**Department of Health Professions**
**9960 Mayland Drive, Suite 300**
**Henrico, VA 23233-1463**
**(804) 367- 4538**

## APPLICATION FOR REINSTATEMENT OF ORAL AND MAXILLOFACIAL SURGEON REGISTRATION OF PRACTICE

**INSTRUCTIONS:** A completed application shall include the following unless otherwise stated below. An incomplete application will delay the processing of your application. Please type or print clearly. If the space provided for any answer is insufficient, you may complete your answer on a separate page, sign the page and enclose it with the application.

**The fee for an application for Reinstatement of Oral and Maxillofacial Surgeon Registration of Practice is $350 and must be paid with a certified check, cashier's check or money order, made payable to The Treasurer of Virginia. Pursuant to 18VAC60-21-40(G) all fees are non-refundable. Your application will not be reviewed until you have submitted payment. Please mail the completed form and the application fee to the address noted above.**

| Name: Last | First | Middle/Maiden | Suffix |
|---|---|---|---|
| | | | |

| Address of Record (Mailing address) | City | State | Zip code | Telephone Number |
|---|---|---|---|---|
| | | | | |
| Publicly 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 OMS Registration Number: | OMS Registration Expiration Date: |
|---|---|---|
| | | |

Have you practiced Oral and Maxillofacial Surgery in Virginia since your registration expired? _____ Yes _____ No

Are you the spouse of a member of the U.S. military who has been transferred to Virginia and did you leave employment to accompany your spouse to Virginia? _____ Yes _____ No

Have you updated your oral and maxillofacial surgeon profile as required for reinstatement of your registration? **Please attach the printed confirmation page showing you have updated this information as required.** _____ Yes _____ No

**PLEASE NOTE**: To update your oral and maxillofacial surgeon profile, you may email your request to info@vahealthprovider.com or call 804-367-4444 Monday-Friday between 8:15am and 5:00pm EST.

By signing below, I certify that I am the person referred to in the forgoing application and the attached supporting documents and that the information on this application and in the attachments is true, complete, and correct to the best of my knowledge. I further certify that I have carefully read the laws and regulations applicable to the registration of oral and maxillofacial surgeons and 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

## Do not write in the spaces below. For office use only:

| Date Received: | Fee: | Rec'd Profile | Registration # | Date Reinstated |
|---|---|---|---|---|
| | | | | |