Virginia Department of Health Professions
Board of Dentistry

9960 Mayland Drive, Suite 300
Henrico, Virginia 23233
(804) 367-4538 (Tel)
(804) 698-4266 (eFax)
denbd@dhp.virginia.gov
www.dhp.virginia.gov/dentistry

INSTRUCTIONS FOR REACTIVATION OF DENTAL HYGIENIST LICENSE

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 remain active for one year from the date of receipt. After one year from date of receipt, you would need to reapply for Virginia licensure. Documents submitted with an application are the property of the Board of Dentistry and cannot be returned.

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

____ 2. **Application Fee**: The fee to reactivate a **dental hygiene license is $75**, 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 18VAC60-25-30(F) all fees are non-refundable. Your application will not be reviewed until you have submitted your payment.

____ 3. **Continuing Education**: You must submit documentation of having completed 15 hours of continuing education (CE) for each year the license was lapsed, up to a total of 45 hours in the 36 months immediately preceding the application for reactivation. Course sponsors and content must meet the requirement in 18VAC60-25-190 of the Regulations Governing the Practice of Dental Hygiene. Of the required hours, at least 15 must be earned in the most recent 12 months immediately preceding your application and the remainder within the 36 months immediately preceding the application. Original documents or copies are accepted.

For example, the 36 months period immediately preceding an application received on October 15, 2018 began on October 16, 2015. The three calendar years for this example application are:

First year:	October 16, 2015 to October 15, 2016
Second year:	October 16, 2016 to October 15, 2017
Third year:	October 16, 2017 to October 15, 2018

Submitted CE documentation **must** include the following:

- Your name
- Name of course completed
- If the subject matter of the course is not evident in the title, you must also submit the sponsor's course description.
- Date(s) in which you completed the course
- Name of the course sponsor; and
- The number of CE credit hours earned

____ 4. **Original NPDB:** A current report, not older than 6 months, must be obtained by Self Query from the National Practitioner Data Bank (NPDB), which may be requested through their website at http://www.npdb.hrsa.gov/. There is a fee for this report. ***This report from NPDB is required from all applicants, without exception. (****Regulation 18VAC60-25-130A(3)****.)***

____ 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. Review the laws and regulations via the "Laws and Regulations" tab at www.dhp.virginia.gov/dentistry.

____ 6. **Name Change:** Documentation must be provided to show each name change(s) if your name has ever been changed from the most recent time you held an active license in Virginia or were licensed in other jurisdictions or other than what is listed on your application. Photocopies of marriage licenses or court orders are accepted.

7. **Address of Record and Publically Disclosable Address:** Consistent with Virginia law §54.1.2400.02 and the mission of the Department of Health Professions, addresses of licensees 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.

Notes:

- **To qualify for reactivation of an inactive license, the applicant must include documentation in the application sufficient to demonstrate continuing competence. Continuing education hours and evidence of active practice in another state or in federal service, recent passage of a clinical competency examination, a refresher program offered by a program accredited by the Commission on Dental Accreditation of the American Dental Association or current certification by a professional credentialing board are considered in determining continuing competence. The optional employment verification form on page 8 may be used to document active practice. Completion of only home study, journal or internet courses is generally not sufficient to demonstrate continuing competence.**

- If your Virginia License 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.

- 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".

- Applicants will be notified of missing application items within approximately 15 business days of receipt of an application. Once your application is complete, allow 30 business days processing time.

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APPLICATION FOR REACTIVATION OF DENTAL HYGIENE LICENSE Page 1

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.

I. GENERAL INFORMATION: COMPLETE ALL SECTIONS (PRINT OR TYPE)

Name: Last*	First	Middle/Maiden	Suffix

Address of Record (Mailing Address)	City	State	Zip Code	Telephone Number
Publically Disclosable Address	**City**	**State**	**Zip Code**	**Telephone Number**

E-Mail Address	Fax #

Date of Birth	Social Security Number or Virginia DMV Control Number on record**
_____/_____/_____ Month Day Year	____ ___ ____--____ ____---____ ____ ____ ____

Virginia License Number	Date Inactive Status Taken	Date of Last Active Practice

Name at Time of Original Licensure (Last, First, Maiden)

***Name change: Documentation must be provided to show name change(s) if name has ever been changed from the time you were licensed in Virginia or other jurisdictions.**

****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 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	Approved	Date License Reactivated	License Number

II. APPLICANT HISTORY: ALL QUESTIONS MUST BE ANSWERED.
If any of the following questions are answered "YES", explain and substantiate with documentation. Letters must be submitted by your attorney regarding malpractice suits. Letters must be submitted by any treating professionals regarding health treatment and shall include diagnosis, treatment and prognosis.

1. Did you relocate with a spouse who is the subject of a military transfer to the Commonwealth of Virginia? If "YES", include a copy of the official military orders with the application. [ ] Yes [ ] No

2. Are you active-duty military? If "YES", include a copy of your official military orders with the application. [ ] Yes [ ] No

Additional licensure questions:

1. A. Within the past five years, have you exhibited any conduct or behavior that could call into question your ability to practice in a competent and professional manner? If "YES", please provide a full explanation. [ ] Yes [ ] No

_____

_____

B. Within the past five years, have you sought or been directed to seek treatment for your conduct or behavior? If "YES", please provide a full explanation. [ ] Yes [ ] No

_____

_____

2. A. Within the past five years, have you been disciplined by any entity? If "YES", please provide a full explanation and any associated orders or letters from the entity. [ ] Yes [ ] No

_____

_____

B. Within the past five years, have you sought or been directed to seek treatment for your conduct or behavior? If "YES", please provide a full explanation and any associated orders or letters. [ ] Yes [ ] No

_____

_____

3. Do you currently have any physical condition or impairment that affects or limits your ability to perform any of the obligations and responsibilities of professional practice in a safe and competent manner? [ ] Yes [ ] No

"Currently" means recently enough so that the condition could reasonably have an impact on your ability to function as a practicing dental assistant II. If "YES", please provide a full explanation. **NOTE:** The Board may request a letter from your current treatment provider addressing your current condition and ability to safely practice. You may consider providing this documentation with your application, or have your provider send this documentation directly to the Board.

_____

_____

4. Do you currently have any mental health condition or impairment that affects or limits your ability to perform any of the obligations and responsibilities of professional practice in a safe and competent manner? [ ] Yes [ ] No

"Currently" means recently enough so that the condition could reasonably have an impact on your ability to function as a practicing dental assistant II. If "YES", please provide a full explanation. **NOTE:** The Board may request a letter from your current treatment provider addressing your current condition and ability to safely practice. You may consider providing this documentation with your application, or have your provider send this documentation directly to the Board.

_____

_____

5. Do you currently have any condition or impairment related to alcohol or other substance use that affects or limits your ability to perform any of the obligations and responsibilities of professional practice in a safe and competent manner? [ ] Yes [ ] No

"Currently" means recently enough so that the condition could reasonably have an impact on your ability to function as a practicing dental assistant II. If "YES", please provide a full explanation. **NOTE:** The Board may request a letter from your current treatment provider addressing your current condition and ability to safely practice. You may consider providing this documentation with your application, or have your provider send this documentation directly to the Board.

_____

_____

6. Within the past 5 years, have any conditions or restrictions been imposed upon you or your practice to avoid disciplinary action by any entity? [ ] Yes [ ] No

If "YES", please provide a full explanation and any associated orders or letters from the entity. **NOTE:** The Board may request a copy of a current participation contract and summary of compliance and/or documentation of successful completion. You may consider providing this documentation with your application, or have the program send this documentation directly to the Board.

_____

_____

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 hygiene. I hereby agree to abide by and remain current with the applicable laws and regulations which are available on www.dhp.virginia.gov/dentistry, 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 _____.

SEAL

_____
Signature of Notary Public

_____
Print Name

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VIRGINIA BOARD OF DENTISTRY CONTINUING EDUCATION COURSES

Complete all information and **include** all required supporting documents.

NAME OF LICENSEE _____ LICENSE NUMBER _____

Pursuant to *18VAC60-25-190.B* of the **Regulations Governing the Practice of Dental Hygiene,** CE programs shall be clinical courses in dental or dental hygiene practice or supportive of clinical services. Courses not acceptable include, but are not limited to: estate planning, financial planning, investments, & personal health.

DATE (in date order)	NAME OF COURSE	APPROVED SPONSOR	NUMBER OF HOURS	BOARD REVIEW

TOTAL HOURS_____

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EMPLOYMENT VERIFICATION

(Optional Form)

(MUST BE COMPLETED BEFORE A NOTARY PUBLIC)

Name of Employing Dentist(s) or Agency:_____

Complete Mailing Address: _____

Telephone Number:_____ Fax Number:_____

Email Address_____

"I, _____ D.D.S./D.M.D./agency representative,
(Print name & Title of the Employing Dentist or Agency Representative)

certify that _____, was employed by me as a _____
(Print Applicant/Employee Name) **(Print Job Title)**

from _____/____/_____ to _____/____/_____, in the clinical, ethical and legal practice of a _____
Month Day Year Month Day Year

_____.

_____ _____
Dentist's/Agency Representative Signature Date

State of _____

County/City of _____

Sworn and subscribed to, before me, this _____day of _____, _____
Day Month Year

My commission expires on _____.
Month Day Year

_____
Signature of Notary Public

SEAL/STAMP

_____
Print Name