



**COMMONWEALTH OF VIRGINIA  
BOARD OF DENTISTRY**

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

**ORAL AND MAXILLOFACIAL SURGEON  
REGISTRATION OF PRACTICE**

INSTRUCTIONS: Use typewriter or print clearly. If the space provided for any answer is insufficient, the registrant must complete his/her answer on a separate page, signed by him/her, specifying the number of the question to which it relates and enclose the page with this application. OMISSIONS OR INACCURACIES ARE GROUNDS FOR REJECTION.

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 ____/____/____			Social Security Number or Virginia DMV Control Number ____-____-____			
Date of Completion of Residency ____/____/____		Name of Residency Program in Oral and Maxillofacial Surgery (must be approved by the Commission on Dental Accreditation of the American Dental Association). Please attach a copy of the certificate of completion:				
Virginia Dental License Number						
Please check Yes or No for each of the following questions. If any of the following questions are answered "YES", please attach documentation.						
					YES	NO
a. Have you ever been convicted of a crime?					_____	_____
b. Have you ever had an action taken against your license by another state board?					_____	_____
c. Have you ever had your hospital privileges revoked or suspended?					_____	_____
10. By signing below, I attest that this application is complete and accurate:						
Signature of applicant _____				Date _____		

**Please mail completed form and the required fee of \$175 (check made payable to "Treasurer of Virginia") to:**

**Department of Health Professions  
Board of Dentistry  
9960 Mayland Drive, Suite 300  
Henrico, VA 23233-1463**

<b>For office use only:</b>				
Date Received	Fee	Pending #	Registration #	Date Issued