

## INSTRUCTIONS FOR REINSTATEMENT OF DENTAL 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. **Reinstatement Application:** Please be sure that all information is completed on the application.
- \_\_\_\_\_ 2. **Fee for lapse of license:** The reinstatement fee for a **dental license is \$500** and must be paid with a certified check, cashier's check or money order, made payable to the **Treasurer of Virginia**.

**Fee for license revocation or suspension:** The reinstatement fee for a previously revoked dental license is **\$1,000** and the fee for a previously suspended dental license is **\$750**.

The fee can be used for one year from date of receipt. Pursuant to 18VAC60-21-40(G), all fees are non-refundable. Your application will not be reviewed until you have submitted payment.

- \_\_\_\_\_ 3. **Form B: Chronology:** List **ALL** activities since expiration of your license. *Resumes and curriculum vitae are not accepted as substitutes for completing the chronological listing and will not be considered.*
- \_\_\_\_\_ 4. **Form C: Original** licensure verification from any jurisdiction in which you currently hold or have ever held a license/registration/certification to practice dentistry or as another health care professional. Copies of permits are not accepted. Verification cannot be older than 6 months from date prepared.
- \_\_\_\_\_ 5. **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 reinstatement. Course sponsors and content must meet the requirement in 18VAC60-21-250 of the Regulations Governing the Practice of Dentistry. 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 three 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

- \_\_\_\_\_ 6. **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 the NPDB is required from all applications, without exception** (Regulation 18VAC60-21-190.3).

- \_\_\_\_\_ 7. 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, 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](http://www.dhp.virginia.gov/dentistry).
- \_\_\_\_\_ 8. **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 on record with the Virginia Board of Dentistry. Photocopies of marriage licenses or court orders are accepted.
- \_\_\_\_\_ 9. **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 reinstatement of a 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 11 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 has not been reinstated within six months of the Board’s receipt 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 complete packet 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.

## APPLICATION FOR REINSTATEMENT OF DENTAL 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
Email Address:		Fax Number:	
Date of Birth ____/____/____ Month Day Year		Social Security Number or <u>Virginia</u> DMV Control Number on record** ____-____-____	
License Number	Date of Expiration	Name at time of Original Licensure:*	

**Please check below, if applicable:**

- REINSTATEMENT REQUESTED DUE TO LAPSE OF LICENSE
- REINSTATEMENT REQUESTED DUE TO SUSPENSION
- REINSTATEMENT REQUESTED DUE TO REVOCATION

**\*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	APPLICANT #	DATE OF REINSTATEMENT	LICENSE #
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**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
3. Have you practiced dentistry since the expiration of your license in the Commonwealth of Virginia or in another jurisdiction? If "YES", give location. [ ] Yes [ ] No
4. Has any of your work since the expiration of your dental license been in any field other than the practice of dentistry? If "YES", give details, jurisdictions(s) and date(s). [ ] Yes [ ] No

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\_\_\_\_\_

5. List all jurisdictions in which you currently hold or have ever held a license / registration / certification to practice dentistry or as any other health care professional:

Jurisdiction	License Number	Date Issued	Expiration Date
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

6. Have you ever been convicted of a violation of or pled Nolo Contendere to any federal, state or local statute, regulation or ordinance, or entered into any plea bargaining relating to a felony or misdemeanor? (Excluding traffic violations, except convictions for driving under the influence.) If "YES", give details, jurisdiction(s) and date(s) **on a separate page**, and include a copy of the disposition record certified by the Clerk of the Court. [ ] Yes [ ] No

7. Have you had any malpractice suits brought against you in the past ten (10) years? [ ] Yes [ ] No  
If "YES", please provide details for each pending or closed case, list additional claim(s) **on a separate page**, and provide a letter from your attorney explaining each case.

Claimant: \_\_\_\_\_ Date of Incident \_\_\_\_\_

Name of Defense Attorney: \_\_\_\_\_

Settlement or Verdict Amount: \_\_\_\_\_

Name of Involved Insurance Company: \_\_\_\_\_

Brief description of the claim: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**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 and any associated orders or letters.  Yes  No

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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

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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

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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 dentist. 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.

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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 dentist. 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.

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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 dentist. 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.

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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.

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**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](http://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



**FORM B  
CHRONOLOGY**

NAME OF APPLICANT: \_\_\_\_\_

Every applicant must provide a complete chronological, personal and professional history of all activities you have engaged in since the expiration of your license, including teaching positions, all periods of non-professional activity or employment, volunteer work and all periods of unemployment. **Curriculum vitae and resumes are not accepted as substitutes for completing the chronological listing and will not be considered.**

*Form B may be photocopied if additional space is needed.*

FROM Month/Year	TO Month/Year	POSITION/ACTIVITY	Employer/Contact Person for practice verification and the person's Complete Address, and Telephone #





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

### FORM C CERTIFICATION OF DENTAL BOARDS

Please forward one form to each state dental/dental hygiene board where you hold or have ever held a dental/dental hygiene license. Some states require a fee, paid in advance, for providing this information. To expedite, you may wish to contact the applicable state board(s). Form C may be photocopied if copies are needed.

**I am making application for licensure in Virginia by:**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Examination for Dental License | <input type="checkbox"/> Examination for Dental Hygiene License | <input type="checkbox"/> Dental Restricted Volunteer License         |
| <input type="checkbox"/> Credentials for Dental License | <input type="checkbox"/> Credentials for Dental Hygiene License | <input type="checkbox"/> Dental Hygiene Restricted Volunteer License |
| <input type="checkbox"/> Dental Faculty License         | <input type="checkbox"/> Dental Hygiene Faculty License         | <input type="checkbox"/> Dental Reinstatement                        |
| <input type="checkbox"/> Dental Temporary Permit        | <input type="checkbox"/> Dental Hygiene Temporary Permit        | <input type="checkbox"/> Dental Hygiene Reinstatement                |

I, was granted License Number \_\_\_\_\_, on \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_ by the State of \_\_\_\_\_  
 Month Date Year.

\_\_\_\_\_. The Virginia Board of Dentistry requires that I submit evidence of the status of my license. You are hereby authorized to release any information in your files, favorable or otherwise directly to the **Virginia Board of Dentistry** at **9960 Mayland Drive, Suite 300, Henrico, Virginia 23233** or [denbd@dhp.virginia.gov](mailto:denbd@dhp.virginia.gov). Your early attention is appreciated.

\_\_\_\_\_  
 Applicant's Signature

\_\_\_\_\_  
 Applicant's Typed/Printed Name

\_\_\_\_\_  
 Applicant's Address

**Executive Officer of the Board: please send this form directly to the Virginia Board of Dentistry.**

State of \_\_\_\_\_ Name of Licensee \_\_\_\_\_

Graduate of \_\_\_\_\_ License # \_\_\_\_\_ Issued \_\_\_\_\_

By:  Examination\*  Credentials  Reciprocity with the State of \_\_\_\_\_  Endorsement with the State of \_\_\_\_\_

\*If licensed by a state administered examination, please provide a score card or report which shows that testing included live patients.

License is:  Current-Expires \_\_\_\_\_  Active  Inactive  Lapsed-Expired \_\_\_\_\_

Has applicant's license ever been disciplined, suspended or revoked  NO  YES

If "YES", give details and attach supporting documentation (Finding of Fact, Conclusions of Law, Orders): \_\_\_\_\_

Comments, if any: \_\_\_\_\_

**SEAL**

\_\_\_\_\_  
 Signature

\_\_\_\_\_  
 Title

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Print Name





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](mailto:denbd@dhp.virginia.gov)  
[www.dhp.virginia.gov/dentistry](http://www.dhp.virginia.gov/dentistry)

## 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  
Month Day Year Month Day Year

practice of a \_\_\_\_\_.

\_\_\_\_\_  
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