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

APPLICATION REQUIREMENTS FOR FACULTY LICENSE (Code 54.1-2713)

An applicant must hold a current unrestricted dental licensee in another U.S. jurisdiction or have completed an advanced dental education program accredited by the Commission on Dental Accreditation of the American Dental Association.

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**. (4 Pages) 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**: Certified check, cashier's check or money order, made payable to the **Treasurer of Virginia** in the amount of $400. The fee can be used for one year from date of receipt. Pursuant to 18 VAC 60-20-40, all fees are non-refundable. A processing fee of $35 will be charged for any check or money order returned unpaid by your bank.

____ **3**. **Form A or Original** documentation of graduation from a dental program is required. The school may use this form or its own form to meet this requirement. The certification must bear the school's seal or be on letterhead. (Faxed copies are not acceptable)

____ **4.** Final **original** transcript bearing SEAL, date degree received and registrar's signature. Copies of transcripts, certificates and diplomas are not acceptable. A transcript or program verification is required for residency/advanced specialty programs.

____ **5. Form B**. Chronology listing **ALL** activities since receiving doctoral degree. (Resumes and curriculum vitas are not required and are not accepted as substitutes for Form B.)

____ **6. Form C**. **Original** licensure verification from any jurisdiction in which you currently hold or have ever held a license to practice dentistry. Copies of licensure permits are not accepted. Verifications cannot be older than 6 months from date prepared.

____ **7. Original**, current report, not older than 6 months from date prepared, obtained by **SELF QUERY** to the National Practitioner Data Bank (NPDB**) and is required from all applicants and should be submitted with the application.**

____ **8**. An **original** grade card **giving scores** issued by the Joint Commission on National Dental Examinations. An original grade card received from the Commission or from the applicant will be kept for one year. Copies of grade cards are not accepted.

____ **9**. Application Affidavit which must be notarized and which 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 applicable Virginia laws and the regulations governing the practice of dentistry.

____ **10. Name Change**. Documentation must be provided to show each name change(s) if your name has ever been changed from the time you attended school or were licensed in other jurisdictions or other than what is listed on your application. Photocopies of marriage licenses or court orders are accepted.

____ **11. Original** letter from the dean or program director of the dental school, on letterhead, noting where the applicant is employed or is to be employed indicating the applicant's employment status and providing an assessment of the applicant's clinical competency and clinical experience that qualifies the applicant for a faculty permit.

FYI

National Practitioner
Data Bank
P.O. Box 10832
Chantilly, VA 20153-0832
1-800-767-6732
www.npdb.hrsa.gov

National Board Scores
American Dental Assoc.
Comm. On Dental Accred.
211 East Chicago Ave.
Chicago, IL 60611-2678
1-800-232-1694
www.ada.org

Approved Programs
American Dental Assoc.
Comm. On Dental Accred.
211 East Chicago Ave.
Chicago, IL 60611-2678
312-44--2500
www.ada.org

Notes:

- **PLEASE NOTE**: If your Virginia License is not issued within six months of the Board's receipt of parts of the application, certain portions of the application may need to be updated/resubmitted before a license can be issued.

- **DEA REGISTRATION**: Applicants must have a dental license prior to applying for a DEA License. Requests for application in Virginia should be make to the following: Drug Enforcement Administration, P.O. Box 28083, Washington, DC 20038-8083, 1-800-882-9539, www.deadiversion.usdoj.gov

- You might obtain the Virginia laws and regulations governing the practice of dentistry on-line at www.dhp.virginia.gov/dentistry..

- 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".

- Within approximately 10 business days of receipt of application, applicants will be notified of missing application items.

- After 10 business days of applying, you might check online to see if your license has been issued by going to www.dhp.virginia.gov and selecting "License Lookup"

- 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 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.

Virginia Board of Dentistry
Virginia Department of Health Professions
9960 Mayland Drive, Suite 300
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APPLICATION FOR A FACULTY LICENSE TO TEACH DENTISTRY

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.

1. GENERAL INFORMATION

Name: Last	First	Middle/Maiden	Suffix

Address of record (Mailing Address)	City	State	Zip	Telephone Number
Public Disclosable Address	City	State	Zip	Telephone Number

Email Address	Fax#

Print Name as you wish it to appear on your license	Place of Birth

Date of Birth	**Social Security Number or Virginia DMV control Number**
_____/_____/_____	____ ____ ____---____ ____--____ ____ ____ ____

DDS/DMD GRADUATION DATE ____ ____ ____ Month Day Year	PROFESSIONAL DEGREE	DENTAL SCHOOL/CITY/STATE OR COUNTRY
ADVANCED PROGRAM GRADUATION DATE ____ ____ ____ Month Day Year	RESIDENCY/SPECIALTY DEGREE or CERTIFICATE	ADA-CODA APPROVED DENTAL SCHOOL/CITY/STATE

APPLICANTS DO NOT USE SPACES BELOW THIS LINE – FOR OFFICE USE ONLY

DATE RECEIVED	CHRONOLOGY (FORM B)	____NATIONAL PRACTITIONER DATA BANK ____HEALTHCARE INTEGRITY AND PROTECTION DATA BANK	NATIONAL BOARD

TRANSCRIPT	CERTIFICATION (EDUCATION) (FORM A)	CERTIFICATION (LICENSE FROM OTHER STATES (Form C or Letter)

FEE	APPLICANT #	LICENSE #	DATE ISSUED	VERIFY NEVER LICENSED IN VIRGINIA

***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 in 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.**

2. ALL EXAMINATIONS **Please answer <u>all</u> "exam" questions "a" through "g"**

a. Southern Regional Testing Agency (SRTA) – Exam Site _____ _____/____/_____
[ ] Passed [ ] Failed [ ] Never Taken [ ] Taken more than once (attach explanation) Month/Day/Year

b. Western Regional Examining Board (WREB) – Exam Site _____ _____/____/_____
[ ] Passed [ ] Failed [ ] Never Taken [ ] Taken more than once (attach explanation) Month/Day/Year

c. North East Regional Board (NERB) – Exam Site _____ _____/____/_____
[ ] Passed [ ] Failed [ ] Never Taken [ ] Taken more than once (attach explanation) Month/Day/Year

d. Central Regional Dental Testing Services, Inc. (CRDTS) –Exam Site_____ _____/____/_____
[ ] Passed [ ] Failed [ ] Never Taken [ ] Taken more than once (attach explanation) Month/Date/Year

e. Council of Interstate Testing Agencies, Inc. (CITA) – Exam Site_____ ____/____/_____
[ ] Passed [ ] Failed [ ] Never Taken [ ] Taken more than once (attach explanation) Month/Date/Year

f. State of _____ –Exam Site_____ _____/____/_____
[ ] Passed [ ] Failed [ ] Never Taken [ ] Taken more than once (attach explanation) Month/Date/Year

g. ADEX _____-Exam Site_____ _____/___/_____
[ ] Passed [ ] Failed [ ] Never taken [ ] Taken more than once (attach explanation)

g. National Board Examination: (Original grade cards are required) _____/____/_____
[ ] Passed [ ] Failed [ ] Never Taken [ ] Taken more than once (attach explanation) Month/Day/Year

3. 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.

a. List in chronological order including months and years, the dental school(s) attended:
(include specialty and advanced programs)

Months & Years	Name of Dental School (ADA-CODA)	Passed/Failed
_____ to _____	_____	_____
_____ to _____	_____	_____
_____ to _____	_____	_____

b. List all jurisdictions in which you have been issued a license to practice dentistry, active or inactive.

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

c. Have you ever been dropped, suspended, expelled, or disciplined by any school or college for any cause whatever? If yes, give details, schools(s), address(es) and date(s) on a separate page. [ ] Yes [ ] No

d. Have you ever been denied a license, or the privilege of taking a dental licensure/competency examination by a licensing authority? If yes, give detail(s), jurisdiction(s) and date(s). [ ] Yes [ ] No

_____

_____

e. Have you ever been convicted of a violation or plead Nolo Contedere, to any federal, state or local statute, regulations 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

f. Have you ever voluntarily surrendered your clinical privileges while under investigation, been censured or warned or been requested to withdraw from the staff of any hospital, nursing home other health care facility, or any health care provider? If yes, give details, jurisdictions(s) and date(s) on a separate page. [ ] Yes [ ] No

g. Have you ever had any of the following disciplinary actions taken against your license to practice dentistry, your DEA permit, Medicare, Medicaid, or are any such actions pending: suspension/revocations, or probations, or reprimand/cease and desist, or monitoring of practice, or limitation placed on scheduled drugs? If yes, give details, jurisdiction(s) and date(s) on a separate page. [ ] Yes [ ] No

h. Have you ever had any membership in a professional society revoked, suspended or sanctioned in any manner? If yes, give details, jurisdiction(s) and date(s) on a separate page. [ ] Yes [ ] No

i Have you ever been a defendant in a military court martial or received medical or other than honorable discharge? If yes, give details, jurisdiction(s) and date(s) on a separate page. [ ] Yes [ ] No

j Have you ever had any malpractice claims brought against you? If yes, give outcome, details, jurisdiction and dates for each claim on a separate page, and provide a letter from your attorney explaining each case. [ ] Yes [ ] No

k. Have you, within the last two (2) years, been physically or emotionally dependent upon the use of alcohol/drugs or been treated by, consulted with, or under the care of a professional for any substance abuse? If yes, give details, jurisdiction(s) and date(s) on a separate page and provide a letter of explanation from the treating professional(s), including a summary of diagnosis, treatment and prognosis. [ ] Yes [ ] No

l. Have you, within the last two (2) years, received treatment for, or been hospitalized for a nervous, emotional or mental disorder? If yes, give details, jurisdiction(s) and date(s) on a separate page, and provide a letter of explanation from the treating professional(s), including a summary of diagnosis, treatment and prognosis. [ ] Yes [ ] No

m. Do you have a physical disability, disease, or diagnosis which could affect your performance or professional duties? If yes, provide a letter of explanation from the treating professional(s), including a summary of diagnosis, treatment, and prognosis. [ ] Yes [ ] No

n. Have you been adjudged mentally incompetent, or been voluntarily or involuntarily committed to a mental institution within the last five (5) years? If yes, give details, jurisdiction(s) and date(s) on a separate page, and provide certified copies of all applicable court documents. [ ] 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 hygiene. 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

COMMONWEALTH OF VIRGINIA

BOARD OF DENTISTRY

Department of Health Professions

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FORM A
CERTIFICATION OF DENTAL/DENTAL HYGIENE SCHOOL

APPLICANT: ENTER YOUR NAME AND GRADUATION DATE BELOW THEN SEND THIS FORM TO THE DEAN OR DIRECTOR OF EACH DENTAL/DENTAL HYGIENE SCHOOL WHICH GRANTED YOU A DEGREE OR CERTIFICATE.

APPLICANT _____ GRADUATION DATE:_____

DEAN/PROGRAM DIRECTOR: Please provide certification that the applicant named above received a dental/dental hygiene degree or certificate from your program and indicate whether or not the program completed was accredited by the Commission on Dental Accreditation of the ADA (CODA). The certification may be provided by completing this form or by providing a letter with the information requested on this form. Either document must bear the school's seal. The certification should be returned to the APPLICANT. Certifications made prior to the applicant's graduation cannot be accepted**.**

NAME OFSCHOOL: _____

NAME OF PROGRAM: _____

PROGRAM'S CODA ACCREDITATION STATUS: _____

DEGREE or CERTIFICATION GRANTED: _____

DATE GRANTED: _____/_____/_____
Month Day Year

By affixing my signature below, I certify that the applicant named above is a graduate and a holder of a diploma or a certificate from a CODA accredited dental program.

_____
Signature

(SEAL)

_____
Title

_____
Date

DEAN/REGISTRAR: Please provide the applicant an original, final transcript of this alumni record, to include courses, grades, degree or certificate received, and date the degree or certificate was conferred, which bears the certified signature of the registrar and has the college seal affixed.

COMMONWEALTH OF VIRGINIA
BOARD OF DENTISTRY

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 receiving your degree or certification, include teaching positions, internship, hospital affiliations, all periods of non-professional activity or employment, volunteer work, and all periods of unemployment.

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

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FORM C

CERTIFICATION OF DENTAL/DENTAL HYGIENE LICENSURE

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:

[ ] Examination for Dental License
[ ] Examination for Dental Hygiene License
[ ] Reinstatement
[ ] Faculty
[ ] Credentials for Dental License
[ ] Endorsement for Dental Hygiene License
[ ] Registration for Volunteer Practice

I, was granted License Number _____, on _____ by the State of
Month Date Year.
_____. The Virginia Board of Dentistry requests that I submit evidence that my license is

in good standing. You are hereby authorized to release any information in your files, favorable or otherwise directly to the

Virginia Board of Dentistry. Your early attention is appreciated.

_____ Applicant's Signature

_____ Applicant's Typed/Printed Name

_____ Applicant's Address

_____

Executive officer of State Board: If no disciplinary action has been taken, please complete and return this form to the applicant. If disciplinary action has been taken, please send the form directly to the Virginia Board of Dentistry.

State of _____ Name of Licensee_____

Graduate of_____ License #_____ Issued_____

By [ ] Reciprocity [ ] Examination* [ ] Endorsement with the State of _____

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

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