

**COMMONWEALTH OF VIRGINIA  
DEPARTMENT OF HEALTH PROFESSIONS  
BOARD OF DENTISTRY  
9960 MAYLAND DRIVE, SUITE 300  
Henrico, VA 23233-1463  
(804) 367-4538 [www.dhp.virginia.gov/dentistry](http://www.dhp.virginia.gov/dentistry)**

**APPLICATION REQUIREMENTS FOR THE FOLLOWING**

Restricted Dental Volunteer License (§ 54.1-2712.1)

Restricted Dental Hygiene Volunteer License (§ 54.1-2726.1)

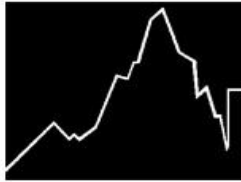
**All required documentation is to be sent to the Board office in a single packet with the application. An incomplete application or submission of single parts or document delay the licensing process. A completed application must include the following:**

- \_\_\_\_\_ 1. Application.
- \_\_\_\_\_ 2. Certified check, cashier's check or money order, made payable to the Treasurer of Virginia in the amount of \$25.
- \_\_\_\_\_ 3. Form AA: If applicable, certification must be provided by the supervising dentists indicating he/she will review the quality of case rendered by the dentist/dental hygienists with the restricted volunteer license at least every thirty days.
- \_\_\_\_\_ 4. Form B: Chronology listing all activities since receiving degree, which must document at least five years of clinical practice.
- \_\_\_\_\_ 5. Form C: Certification of licensure not older than 6 months from each jurisdiction in which you have or ever held a license to practice dentistry. Copies of licenses or permits are not accepted. Certification is not required if you ever held a license in Virginia. Please list all states under Section "b" under Applicant History on page 2 of the application.
- \_\_\_\_\_ 6. Certify that you have not failed a clinical licensure examination within the last five years. Item "d" on page 3 of application.
- \_\_\_\_\_ 7. 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 will remain current with the applicable Virginia dental and dental hygiene laws and regulations of the Virginia Board of Dentistry. In addition, no remuneration will be received directly or indirectly for dental/dental hygiene services. A passport-type photo not older than 6 months is required.
- \_\_\_\_\_ 8. Documentation must be provided to show each name change made since receiving your degree. Photocopies of marriage licenses or court orders are accepted.

\_\_\_\_\_ 9. Original, current reports, not older than 6 months, from the (1) Healthcare Integrity and Protection Data Bank (HIPDB) AND (2) National Practitioner Data Bank (NPDB) (Regulation 18 VAC 60-20-100 and should be submitted with the application. These two reports can be obtained from [www.npdb-hipdb.hrsa.gov](http://www.npdb-hipdb.hrsa.gov)., 1-800- 767-6732, P. O. Box 10832, Chantilly, VA 20153-0832. Copies are not acceptable.

#### NOTES:

- 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.
- You may obtain the Virginia dental and dental hygiene laws and regulations of the Virginia Board of Dentistry on-line at [www.dhp.virginia.gov/dentistry](http://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”.
- After 10 business days of applying, you might check on-line to see if your license has been issued by going to [www.dhp.virginia.gov](http://www.dhp.virginia.gov) and selecting License Lookup.
- Applicants who submit an incomplete application will be notified within 10 business days of receipt that required information is missing.
- 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.
- Documents submitted with an application are the property of the board and cannot be returned.



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 Board of Dentistry  
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**APPLICATION FOR RESTRICTED VOLUNTEER LICENSE TO PRACTICE  
 DENTISTRY OR DENTAL HYGIENE**

- ( ) DENTAL RESTRICTED VOLUNTEER LICENSE  
 ( ) DENTAL HYGIENIST RESTRICTED VOLUNTEER LICENSE

**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 enclosed it with the application.

**I. 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 #		
Date of Birth ____/____/____					Social Security Number or Virginia DMV Control Number ____-____-____		
Dental Specialty Graduate Date ____/____/____ Month Date Year		Specialty Degree Or Certificate	ADA-Coda Approved Dental School		City/State		
<b>FOR OFFICE USE ONLY</b>							
Date Received		Form AA	Form B	Form C –Certification of Licensure			
____ National Practitioner Data Bank				____ Healthcare Integrity and Protection Data Bank			
Fee		APPLICANT #		LICENSE #		DATE ISSUED	

\*Name change: Documentation must be provided to show name changes(s) if name has ever 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 Number or 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 required that this number be shared with other agencies for child support enforcement activities.

**APPLICANT HISTORY**

List in chronological order, including months and years, the dental/dental hygiene school(s) attended.

Months & Years	Name of Dental/Dental Hygiene School	Passed or Failed or Graduated
_____ to _____	_____	_____
_____ to _____	_____	_____

b. List all jurisdictions where you have been issued a license to practice dentistry/dental hygiene, active or inactive. Indicate license number and date issued.

Jurisdiction	License Number	Date Issued	State Active or Inactive
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

- 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 failed a dental licensing examination(s)?  Yes  No  
If yes, give details, jurisdiction(s) and date(s).\_\_\_\_\_
- f. 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
- g. 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
- h. 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
- i. 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
- j. 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
- k. Have you ever had any malpractice suits brought against you? If yes, give details, jurisdiction(s) and date(s) for each suit on a separate page, and provide a letter from your attorney explaining each case.  Yes  No
- l. 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
- m. 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
- n. 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
- o. 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



**FORM AA**

**FOR DENTAL APPLICANTS:** You may be required now or will be required in the future to have a sponsoring dentist in order to hold a restricted volunteer license. When you are required to have a sponsor is determined by your practice history as reported on FORM B: CHRONOLOGY and your answers below. You must have a sponsor if you have not been in active practice within the past five years of making application.

**NAME OF APPLICANT:** \_\_\_\_\_ **Dental Restricted Volunteer License**

1. Name of address of clinic you will be volunteering at:  
\_\_\_\_\_  
\_\_\_\_\_
  2. Are you still in active practice: Yes \_\_\_\_\_ No \_\_\_\_\_
  3. If you answered no above, please give the month and year when you were last in active practice. Month \_\_\_\_\_ Year \_\_\_\_\_
  4. How many years have passed since your last date of service: Calculate by subtracting the month and year reported above from the current month and year:  
Number of Months \_\_\_\_\_/Number of years \_\_\_\_\_
  5. a. If your answer above is less than five years then you do not presently need a sponsor and you may stop here. The date when you must have a sponsor will be specified on your restricted volunteer license. It is your responsibility to obtain and report your sponsor by the date specified on your license. You may voluntarily obtain and report a sponsor with your application.
- OR**
- b. If your answer above is five years or greater then your sponsor must provide the information requested below.

**TO BE COMPLETED BY SPONSOR**

6. By affixing my signature below, I will review the quality of care rendered by the above named applicant at least every 30 days who will only treat patients who have been screened by the approved clinic and are eligible for treatment. I will directly observe patient care being provided and review all patient charts at least quarterly. Such supervision shall be noted in patient charts and maintained in accordance with 18 VAC 60-20-15.

\_\_\_\_\_  
Signature of Sponsor

\_\_\_\_\_  
Virginia License Number

**COMMONWEALTH OF VIRGINIA  
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**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.

Only applicants for dental **licensure by credentials** are required to provide the Number of Hours of Clinical Practice. You must report the number of hours you were engaged in clinical practice for each dental position you held within the six year period prior to submitting this application. Report multiple year positions as hours per calendar year, i.e. 600 hours in 2004 or 1000 hours each year for 200-2004.

*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 #	Number of Hours of Clinical Practice



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**FORM C**

**CERTIFICATION OF DENTAL/DENTAL HYGIENE 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"/> Credentials for Dental License         |
| <input type="checkbox"/> Examination for Dental Hygiene License | <input type="checkbox"/> Endorsement for Dental Hygiene License |
| <input type="checkbox"/> Reinstatement                          | <input type="checkbox"/> Teachers License                       |
| <input type="checkbox"/> Full Time Faculty                      | <input type="checkbox"/> Registration for Volunteer Practice    |

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

requests that I submit evidence that my license in the State of \_\_\_\_\_

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  If licensed by state clinical exam, provide year and check her if exam included treatment of live patient \_\_\_\_\_  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): \_\_\_\_\_  
\_\_\_\_\_

Derogatory information, if any: \_\_\_\_\_

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

SEAL	_____	_____	_____
	Signature	Title	Date