COMMONWEALTH OF VIRGINIA
BOARD OF DENTISTRY

Department of Health Professions
9960 Mayland Drive, Suite 300
Richmond, VA 23233-1463
(804) 367-4538, www.dhp.virginia.gov/dentistry

APPLICATION FOR CERTIFICATION TO PERFORM COSMETIC PROCEDURES

INSTRUCTIONS: Use typewriter or print clearly. If the space provided for any answer is insufficient, the applicant 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
Public disclosable Address	**City**	**State**	**Zip Code**	**Telephone Number**

Email Address	Fax#
Date of Birth ____ ___/____ ____/____ ___ ___ ___	Social Security Number or Virginia DMV Control Number ____ ___ ___ -____ ___ -____ ____ ____ ____
Virginia Dental License Number:	Virginia Oral and Maxillofacial Surgical Practice Registration Number:

Name of Practice (if applicable):	

Check only one and attach copy of documentation of American Board of Oral and Maxillofacial Surgery:

_____ Certification **OR** _____ Eligibility

Hospital privileges for Oral and Maxillofacial surgery are current at: Provide a copy of the letter confirming the privileges granted.

Certification is sought for (check all that apply): Fill out a procedure form and attach documentation for each certification you check.

A. [ ] Rhinoplasty/similar procedures
B. [ ] Blepharoplasty/similar procedures
C. [ ] Rhytidectomy/similar procedures
D. [ ] Submental liposuction/similar procedures
E. [ ] Browlift/either open or endoscopic technique/similar procedures
F. [ ] Otoplasty/similar procedures
G. [ ] Laser resurfacing or dermabrasion/similar procedures
H. [ ] Platysmal muscle plication/similar procedures

11. By signing below, I attest that this application is complete and accurate:

_____ _____
Signature of applicant Date

Please mail completed Application and Procedure forms with the required fee of $225 (check made payable to "Treasurer of Virginia") to:

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

Revised March 23,2012

FOR OFFICE USE ONLY

Date Received	Fee	Pending #	Certification #	Date Issued

RHINOPLASTY/SIMILAR PROCEDURES

1. Name (Last, First, M.I., Suffix, Maiden Name)	2. Virginia Dental License Number:

3. Oral and Maxillofacial Residency Program (must be approved by the Commission on Dental Accreditation of the American Dental Association)

at _____ was completed

by the applicant on the following date_____. Attach a copy of the certificate.

4. Check the blank space in front of A or B below to indicate which requirement applies to you, then attach the appropriate documentation:

_____ A. If the residency program completion date is after July 1, 1996, **and** training in cosmetic procedures was part of the residency, attach the following:

1. A letter from the program director documenting the training provided in rhinoplasty/similar procedures, and,
2. Documentation from the program that the applicant performed, as primary or assistant surgeon, at least 10 proctored cases in rhinoplasty/similar procedures.

OR

_____ B. If the residency program completion date is prior to July 1, 1996, and in any case where the residency program did not include training in cosmetic procedures, attach the following:

1. A list of approved didactic and clinical courses specific to rhinoplasty/similar procedures that include the title of the course, the dates attended, and the location of the course.
   Attach a copy of the certificate of attendance for each course listed.
   NOTE: To be approved, the courses must have been obtained from one of the following:
   a. an advanced specialty education program in oral and maxillofacial surgery accredited by the Commission on Dental Accreditation
   b. a medical school accredited by the Liaison Committee on Medical Education or other official accrediting body recognized by the American Medical Association
   c. the American Dental Association (ADA) or one of its constituent or component societies or other ADA Continuing Education Recognized Programs (CERP) approved for continuing dental education, or
   d. the American Medical Association, approved for category 1, continuing medical education.

AND

2.a. Documentation of current privileges to perform cosmetic surgical procedures within a hospital accredited by the Joint Commission on Accreditation of Healthcare Organizations, or

b. Patient operative records with patient names fully obscured, for at least 10 cases in rhinoplasty/similar procedures documenting you as the primary or secondary surgeon. At least 5 of the ten cases must have been proctored. Attach a signed statement from the proctor that specifies the number of rhinoplasty/similar procedures proctored.

BLEPHAROPLASTY/SIMILAR PROCEDURES

1. Name (Last, First, M.I., Suffix, Maiden Name)	2. Virginia Dental License Number:

3. Oral and Maxillofacial Residency Program (must be approved by the Commission on Dental Accreditation of the American Dental Association)

at _____ was completed

by the applicant on the following date_____. Attach a copy of the certificate.

4. Check the blank space in front of A or B below to indicate which requirement applies to you, then attach the appropriate documentation:

_____ A. If the residency program completion date is after July 1, 1996, **and** training in cosmetic procedures was part of the residency, attach the following:

1. A letter from the program director documenting the training provided in blepharoplasty/similar procedures, and,
2. Documentation from the program that the applicant performed, as primary or assistant surgeon, at least 10 proctored cases in blepharoplasty/similar procedures.

OR

_____ B. If the residency program completion date is prior to July 1, 1996, and in any case where the residency program did not include training in cosmetic procedures, attach the following:

1. A list of approved didactic and clinical courses specific to blepharoplasty/similar procedures that include the title of the course, the dates attended, and the location of the course.
   Attach a copy of the certificate of attendance for each course listed.
   NOTE: To be approved, the courses must have been obtained from one of the following:
   a. an advanced specialty education program in oral and maxillofacial surgery accredited by the Commission on Dental Accreditation
   b. a medical school accredited by the Liaison Committee on Medical Education or other official accrediting body recognized by the American Medical Association
   c. the American Dental Association (ADA) or one of its constituent or component societies or other ADA Continuing Education Recognized Programs (CERP) approved for continuing dental education, or
   d. the American Medical Association, approved for category 1, continuing medical education.

AND

2.a. Documentation of current privileges to perform cosmetic surgical procedures within a hospital accredited by the Joint Commission on Accreditation of Healthcare Organizations, or

b. Patient operative records with patient names fully obscured, for at least 10 cases in blepharoplasty/similar procedures documenting you as the primary or secondary surgeon. At least 5 of the ten cases must have been proctored. Attach a signed statement from the proctor that specifies the number of blepharoplasty/similar procedures proctored.

RHYTIDECTOMY/SIMILAR PROCEDURES

1. Name (Last, First, M.I., Suffix, Maiden Name)	2. Virginia Dental License Number:

3. Oral and Maxillofacial Residency Program (must be approved by the Commission on Dental Accreditation of the American Dental Association)

at _____ was completed

by the applicant on the following date_____. Attach a copy of the certificate.

4. Check the blank space in front of A or B below to indicate which requirement applies to you, then attach the appropriate documentation:

_____ A. If the residency program completion date is after July 1, 1996, **and** training in cosmetic procedures was part of the residency, attach the following:

1. A letter from the program director documenting the training provided in rhytidectomy/similar procedures, and,
2. Documentation from the program that the applicant performed, as primary or assistant surgeon, at least 10 proctored cases in rhytidectomy/similar procedures.

OR

_____ B. If the residency program completion date is prior to July 1, 1996, and in any case where the residency program did not include training in cosmetic procedures, attach the following:

1. A list of approved didactic and clinical courses specific to rhytidectomy/similar procedures that include the title of the course, the dates attended, and the location of the course.
   Attach a copy of the certificate of attendance for each course listed.
   NOTE: To be approved, the courses must have been obtained from one of the following:
   a. an advanced specialty education program in oral and maxillofacial surgery accredited by the Commission on Dental Accreditation
   b. a medical school accredited by the Liaison Committee on Medical Education or other official accrediting body recognized by the American Medical Association
   c. the American Dental Association (ADA) or one of its constituent or component societies or other ADA Continuing Education Recognized Programs (CERP) approved for continuing dental education, or
   d. the American Medical Association, approved for category 1, continuing medical education.

AND

2.a. Documentation of current privileges to perform cosmetic surgical procedures within a hospital accredited by the Joint Commission on Accreditation of Healthcare Organizations, or

b. Patient operative records with patient names fully obscured, for at least 10 cases in rhytidectomy/similar procedures documenting you as the primary or secondary surgeon. At least 5 of the ten cases must have been proctored. Attach a signed statement from the proctor that specifies the number of rhytidectomy/similar procedures proctored.

SUBMENTAL LIPOSUCTION/SIMILAR PROCEDURES

1. Name (Last, First, M.I., Suffix, Maiden Name)	2. Virginia Dental License Number:

3. Oral and Maxillofacial Residency Program (must be approved by the Commission on Dental Accreditation of the American Dental Association)

at _____ was completed

by the applicant on the following date_____. Attach a copy of the certificate.

4. Check the blank space in front of A or B below to indicate which requirement applies to you, then attach the appropriate documentation:

_____ A. If the residency program completion date is after July 1, 1996, **and** training in cosmetic procedures was part of the residency, attach the following:

1. A letter from the program director documenting the training provided in submental liposuction/similar procedures, and,
2. Documentation from the program that the applicant performed, as primary or assistant surgeon, at least 10 proctored cases in submental liposuction/similar procedures.

OR

_____ B. If the residency program completion date is prior to July 1, 1996, and in any case where the residency program did not include training in cosmetic procedures, attach the following:

1. A list of approved didactic and clinical courses specific to submental liposuction/similar procedures that include the title of the course, the dates attended, and the location of the course.
   Attach a copy of the certificate of attendance for each course listed.
   NOTE: To be approved, the courses must have been obtained from one of the following:
   a. an advanced specialty education program in oral and maxillofacial surgery accredited by the Commission on Dental Accreditation
   b. a medical school accredited by the Liaison Committee on Medical Education or other official accrediting body recognized by the American Medical Association
   c. the American Dental Association (ADA) or one of its constituent or component societies or other ADA Continuing Education Recognized Programs (CERP) approved for continuing dental education, or
   d. the American Medical Association, approved for category 1, continuing medical education.

AND

2.a. Documentation of current privileges to perform cosmetic surgical procedures within a hospital accredited by the Joint Commission on Accreditation of Healthcare Organizations, or

b. Patient operative records with patient names fully obscured, for at least 10 cases in submental liposuction/similar procedures documenting you as the primary or secondary surgeon. At least 5 of the ten cases must have been proctored. Attach a signed statement from the proctor that specifies the number of submental liposuction/similar procedures proctored.

BROWLIFT/EITHER OPEN OR ENDOSCOPIC TECHNIQUE/ SIMILAR PROCEDURES

1. Name (Last, First, M.I., Suffix, Maiden Name)	2. Virginia Dental License Number:

3. Oral and Maxillofacial Residency Program (must be approved by the Commission on Dental Accreditation of the American Dental Association)

at _____ was completed

by the applicant on the following date_____. Attach a copy of the certificate.

4. Check the blank space in front of A or B below to indicate which requirement applies to you, then attach the appropriate documentation:

_____ A. If the residency program completion date is after July 1, 1996, **and** training in cosmetic procedures was part of the residency, attach the following:

1. A letter from the program director documenting the training provided in browlift/either open or endoscopic technique/similar procedures, and,
2. Documentation from the program that the applicant performed, as primary or assistant surgeon, at least 10 proctored cases in browlift/either open or endoscopic technique/similar procedures.

OR

_____ B. If the residency program completion date is prior to July 1, 1996, and in any case where the residency program did not include training in cosmetic procedures, attach the following:

1. A list of approved didactic and clinical courses specific to browlift/either open or endoscopic technique/similar procedures that include the title of the course, the dates attended, and the location of the course.

   Attach a copy of the certificate of attendance for each course listed.

   NOTE: To be approved, the courses must have been obtained from one of the following:

   a. an advanced specialty education program in oral and maxillofacial surgery accredited by the Commission on Dental Accreditation
   b. a medical school accredited by the Liaison Committee on Medical Education or other official accrediting body recognized by the American Medical Association
   c. the American Dental Association (ADA) or one of its constituent or component societies or other ADA Continuing Education Recognized Programs (CERP) approved for continuing dental education, or
   d. the American Medical Association, approved for category 1, continuing medical education.

AND

2.a. Documentation of current privileges to perform cosmetic surgical procedures within a hospital accredited by the Joint Commission on Accreditation of Healthcare Organizations, or

b. Patient operative records with patient names fully obscured, for at least 10 cases in browlift/either open or endoscopic technique/similar procedures documenting you as the primary or secondary surgeon. At least 5 of the ten cases must have been proctored. Attach a signed statement from the proctor that specifies the number of browlift/either open or endoscopic technique/similar procedures proctored.

OTOPLASTY/SIMILAR PROCEDURES

1. Name (Last, First, M.I., Suffix, Maiden Name)	2. Virginia Dental License Number:

3. Oral and Maxillofacial Residency Program (must be approved by the Commission on Dental Accreditation of the American Dental Association)

at _____ was completed

by the applicant on the following date_____. Attach a copy of the certificate.

4. Check the blank space in front of A or B below to indicate which requirement applies to you, then attach the appropriate documentation:

_____ A. If the residency program completion date is after July 1, 1996, **and** training in cosmetic procedures was part of the residency, attach the following:

1. A letter from the program director documenting the training provided in otoplasty/similar procedures, and,
2. Documentation from the program that the applicant performed, as primary or assistant surgeon, at least 10 proctored cases in otoplasty/similar procedures.

OR

_____ B. If the residency program completion date is prior to July 1, 1996, and in any case where the residency program did not include training in cosmetic procedures, attach the following:

1. A list of approved didactic and clinical courses specific to otoplasty/similar procedures that include the title of the course, the dates attended, and the location of the course.
   Attach a copy of the certificate of attendance for each course listed.
   NOTE: To be approved, the courses must have been obtained from one of the following:
   a. an advanced specialty education program in oral and maxillofacial surgery accredited by the Commission on Dental Accreditation
   b. a medical school accredited by the Liaison Committee on Medical Education or other official accrediting body recognized by the American Medical Association
   c. the American Dental Association (ADA) or one of its constituent or component societies or other ADA Continuing Education Recognized Programs (CERP) approved for continuing dental education, or
   d. the American Medical Association, approved for category 1, continuing medical education.

AND

2.a. Documentation of current privileges to perform cosmetic surgical procedures within a hospital accredited by the Joint Commission on Accreditation of Healthcare Organizations, or

b. Patient operative records with patient names fully obscured, for at least 10 cases in otoplasty/similar procedures documenting you as the primary or secondary surgeon. At least 5 of the ten cases must have been proctored. Attach a signed statement from the proctor that specifies the number of otoplasty/similar procedures proctored.

LASER RESURFACING OR DERMABRASION/SIMILAR PROCEDURES

1. Name (Last, First, M.I., Suffix, Maiden Name)	2. Virginia Dental License Number:

3. Oral and Maxillofacial Residency Program (must be approved by the Commission on Dental Accreditation of the American Dental Association)

at _____ was completed

by the applicant on the following date_____. Attach a copy of the certificate.

4. Check the blank space in front of A or B below to indicate which requirement applies to you, then attach the appropriate documentation:

_____ A. If the residency program completion date is after July 1, 1996, **and** training in cosmetic procedures was part of the residency, attach the following:

1. A letter from the program director documenting the training provided in laser resurfacing or dermabrasion/similar procedures, and,
2. Documentation from the program that the applicant performed, as primary or assistant surgeon, at least 10 proctored cases in laser resurfacing or dermabrasion/similar procedures.

OR

_____ B. If the residency program completion date is prior to July 1, 1996, and in any case where the residency program did not include training in cosmetic procedures, attach the following:

1. A list of approved didactic and clinical courses specific to laser resurfacing or dermabrasion/similar procedures that include the title of the course, the dates attended, and the location of the course. Attach a copy of the certificate of attendance for each course listed.

NOTE: To be approved, the courses must have been obtained from one of the following:

a. an advanced specialty education program in oral and maxillofacial surgery accredited by the Commission on Dental Accreditation
b. a medical school accredited by the Liaison Committee on Medical Education or other official accrediting body recognized by the American Medical Association
c. the American Dental Association (ADA) or one of its constituent or component societies or other ADA Continuing Education Recognized Programs (CERP) approved for continuing dental education, or
d. the American Medical Association, approved for category 1, continuing medical education.

AND

2.a. Documentation of current privileges to perform cosmetic surgical procedures within a hospital accredited by the Joint Commission on Accreditation of Healthcare Organizations, or

b. Patient operative records with patient names fully obscured, for at least 10 cases in laser resurfacing or dermabrasion/similar procedures documenting you as the primary or secondary surgeon. At least 5 of the ten cases must have been proctored. Attach a signed statement from the proctor that specifies the number of laser resurfacing or dermabrasion/similar procedures proctored.

PLATYSMAL MUSCLE PLICATION/SIMILAR PROCEDURES

1. Name (Last, First, M.I., Suffix, Maiden Name)	2. Virginia Dental License Number:

3. Oral and Maxillofacial Residency Program (must be approved by the Commission on Dental Accreditation of the American Dental Association)

at _____ was completed

by the applicant on the following date_____. Attach a copy of the certificate.

4. Check the blank space in front of A or B below to indicate which requirement applies to you, then attach the appropriate documentation:

_____ A. If the residency program completion date is after July 1, 1996, **and** training in cosmetic procedures was part of the residency, attach the following:

1. A letter from the program director documenting the training provided in platysmal muscle plication/similar procedures, and,
2. Documentation from the program that the applicant performed, as primary or assistant surgeon, at least 10 proctored cases in platysmal muscle plication/similar procedures.

OR

_____ B. If the residency program completion date is prior to July 1, 1996, and in any case where the residency program did not include training in cosmetic procedures, attach the following:

1. A list of approved didactic and clinical courses specific to platysmal muscle plication/similar procedures that include the title of the course, the dates attended, and the location of the course.
   Attach a copy of the certificate of attendance for each course listed.
   NOTE: To be approved, the courses must have been obtained from one of the following:
   a. an advanced specialty education program in oral and maxillofacial surgery accredited by the Commission on Dental Accreditation
   b. a medical school accredited by the Liaison Committee on Medical Education or other official accrediting body recognized by the American Medical Association
   c. the American Dental Association (ADA) or one of its constituent or component societies or other ADA Continuing Education Recognized Programs (CERP) approved for continuing dental education, or
   d. the American Medical Association, approved for category 1, continuing medical education.

AND

2.a. Documentation of current privileges to perform cosmetic surgical procedures within a hospital accredited by the Joint Commission on Accreditation of Healthcare Organizations, or

b. Patient operative records with patient names fully obscured, for at least 10 cases in platysmal muscle plication/similar procedures documenting you as the primary or secondary surgeon. At least 5 of the ten cases must have been proctored. Attach a signed statement from the proctor that specifies the number of platysmal muscle plication/similar procedures proctored.