

#### COMMONWEALTH OF VIRGINIA BOARD OF DENTISTRY

Department of Health Professions 9960 Mayland Drive, Suite 300 Richmond, VA 2323-1463

(804) 367-4538, www.dhp.virginia.gov/dentistry

#### APPLICATION FOR CERTIFICATION O PERFORM COSMETIC PROCEDURES

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 docume	ntation of American Board of (	Oral and Maxil	lofacial Surgery:		
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 E. [ ] Browlift/either open or endoscopic technique/simi procedures			oscopic technique/similar		
B. [ ] Blepharoplasty/similar procedures		F. [	] Otoplasty/s	imilar procedur	es
C. [ ] Rhytidectomy/similar D. [ ] Submental liposuction		G. [ ] Laser resurfacing or dermabrasion/similar procedu dures H. [ ] Platysmal muscle plication/similar procedures			
11. By signing below, I attest that this applic	cation is complete and accurat	e:			
Signature of applicant					Date
Disco mail completed An	alightian and Draged			au lucal foo	f ¢225 (abaals made

# 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:	which requirement apples to you, then attach the appropriate	
	er 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,	
proctored cases in rhinoplasty/similar procedure	icant performed, as primary or assistant surgeon, at least 10	
OR		
	or to July 1, 1996, and in any case where the residency	
program did not include training in cosmetic proce		
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 locat		
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		
	ommittee on Medical Education or other official accrediting	
body recognized by the American Medical As		
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.		
a. The American Medical Association, approved for category 1, continuing medical education.		
	n cosmetic surgical procedures within a hospital accredited	
by the Joint Commission on Accreditation of		
	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		
	om 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:	which requirement applies to you, then attach the appropriate	
	er July 1, 1996, <u>and</u> training in cosmetic procedures was part	
of the residency, attach the following:		
	the training provided in blepharoplasty/similar procedures,	
and,	icant performed, as primary or assistant surgeon, at least 10	
proctored cases in blepharoplasty/similar proce		
OR		
	or to July 1, 1996, and in any case where the residency	
program did not include training in cosmetic proce		
	specific to blepharoplasty/similar procedures that include the	
title of the course, the dates attended, and the l Attach a copy of the certificate of attendance for		
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 C	ommittee on Medical Education or other official accrediting	
body recognized by the American Medical As		
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		
<ul> <li>d. the American Medical Association, approved for category 1, continuing medical education.</li> <li>AND</li> </ul>		
	n cosmetic surgical procedures within a hospital accredited	
by the Joint Commission on Accreditation of I		
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 data	Attack a convict the partificate	
by the applicant on the following date	Allach a copy of the certificate.	
4. Check the blank space in front of A or B below to indicate documentation:	which requirement applies to you, then attach the appropriate	
	en luk 4,4000 and training in a second is a second way and	
of the residency, attach the following:	er July 1, 1996, <u>and</u> training in cosmetic procedures was part	
	the training provided in rhytidectomy/similar procedures,	
and,		
<ol><li>Documentation from the program that the appl proctored cases in rhytidectomy/similar procedule</li></ol>	icant performed, as primary or assistant surgeon, at least 10 ures.	
OR		
OR		
B. If the residency program completion date is pri	or 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 l Attach a copy of the certificate of attendance for		
NOTE: To be approved, the courses must have		
a. an advanced specialty education program in	oral and maxillofacial surgery accredited by the Commission	
on Dental Accreditation		
	ommittee 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		
AND		
	m cosmetic surgical procedures within a hospital accredited	
by the Joint Commission on Accreditation of	Healthcare Organizations, or fully obscured, for at least 10 cases in rhytidectomy/similar	
	or secondary surgeon. At least 5 of the ten cases must have	
been proctored. Attach a signed statement fr		
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 documentation:	which requirement applies to you, then attach the appropriate	
A If the residency program completion data is off	er July 1, 1996, <b>and</b> training in cosmetic procedures was part	
of the residency, attach the following:	er July 1, 1996, <b>and</b> training in cosmetic procedures was part	
	the training provided in submental liposuction/similar	
procedures, and,		
	icant performed, as primary or assistant surgeon, at least 10	
proctored cases in submental liposuction/simila	r procedures.	
OR		
D. If the residency program completion data is pri	or to July 1, 1006, and in any apparture the residency	
program did not include training in cosmetic proce	or to July 1, 1996, and in any case where the residency	
	specific to submental liposuction/similar procedures that	
include the title of the course, the dates attende	d, and the location of the course.	
Attach a copy of the certificate of attendance for		
NOTE: To be approved, the courses must have		
<ul> <li>an advanced specialty education program in oral and maxillofacial surgery accredited by the Commission on Dental Accreditation</li> </ul>		
	ommittee on Medical Education or other official accrediting	
body recognized by the American Medical As		
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	n cosmetic surgical procedures within a hospital accredited	
by the Joint Commission on Accreditation of		
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 proc	stored.	

#### BROWLIFT/EITHER OPEN OR ENDOSCOPIC TECHNIQUE/ SIMILAR PROCEDURES

1. Name (Last, First, M.I., Suffix, Maiden Name)	2. Virginia Dental License Number:	
<ol> <li>Oral and Maxillofacial Residency Program (must be approved by Association)</li> </ol>	the Commission on Dental Accreditation of the American Dental	
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 documentation:	which requirement applies to you, then attach the appropriate	
of the residency, attach the following:	er July 1, 1996, <u>and</u> training in cosmetic procedures was part	
technique/similar procedures, and,	the training provided in browlift/either open or endoscopic	
<ol><li>Documentation from the program that the appli proctored cases in browlift/either open or endos</li></ol>	cant performed, as primary or assistant surgeon, at least 10 scopic technique/similar procedures.	
OR		
<ul> <li>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:</li> <li>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.</li> </ul>		
Attach a copy of the certificate of attendance for NOTE: To be approved, the courses must have		
on Dental Accreditation b. a medical school accredited by the Liaison C body recognized by the American Medical As	ommittee on Medical Education or other official accrediting	
<ul> <li>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</li> <li>d. the American Medical Association, approved for category 1, continuing medical education.</li> </ul>		
AND		
<ol> <li>2.a. Documentation of current privileges to perforr by the Joint Commission on Accreditation of I</li> </ol>	n cosmetic surgical procedures within a hospital accredited Healthcare Organizations, or	
<ul> <li>b. Patient operative records with patient names endoscopic technique/similar procedures doct</li> </ul>	fully obscured, for at least 10 cases in browlift/either open or umenting you as the primary or secondary surgeon. At least Attach a signed statement from the proctor that specifies the	

### 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 documentation:	which requirement applies to you, then attach the appropriate		
<ul> <li>A. If the residency program completion date is after July 1, 1996, <u>and</u> training in cosmetic procedures was part of the residency, attach the following:</li> <li>1. A letter from the program director documenting the training provided in otoplasty/similar procedures, and,</li> <li>2. Documentation from the program that the applicant performed, as primary or assistant surgeon, at least 10 proctored cases in otoplasty/similar procedures.</li> </ul>			
<ul> <li>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: <ol> <li>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.</li> <li>Attach a copy of the certificate of attendance for each course listed.</li> <li>NOTE: To be approved, the courses must have been obtained from one of the following: <ol> <li>an advanced specialty education program in oral and maxillofacial surgery accredited by the Commission on Dental Accreditation</li> <li>a medical school accredited by the Liaison Committee on Medical Education or other official accrediting body recognized by the American Medical Association</li> <li>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</li> <li>the American Medical Association, approved for category 1, continuing medical education.</li> </ol> </li> <li>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</li> <li>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.</li> </ol> </li> </ul>			

## 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 Association)	/ the Commission on Dental Accreditation of the American Dental	
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 documentation:	which requirement applies to you, then attach the appropriate	
<ul> <li>A. If the residency program completion date is after July 1, 1996, <u>and</u> training in cosmetic procedures was part of the residency, attach the following:</li> <li>1. A letter from the program director documenting the training provided in laser resurfacing or dermabrasion/similar procedures, and,</li> <li>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.</li> </ul>		
OR		
<ul> <li>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:</li> <li>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.</li> <li>NOTE: To be approved, the courses must have been obtained from one of the following:</li> <li>a. an advanced specialty education program in oral and maxillofacial surgery accredited by the Commission on Dental Accreditation</li> <li>b. a medical school accredited by the Liaison Committee on Medical Education or other official accrediting body recognized by the American Medical Association</li> <li>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</li> <li>d. the American Medical Association, approved for category 1, continuing medical education.</li> </ul> <b>Ano</b> 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 procedures proctored.		

## PLATYSMAL MUSCLE PLICATION/SIMILAR PROCEDURES

2. Virginia Dental License Number:		
the Commission on Dental Accreditation of the American Dental		
was completed		
Attach a copy of the certificate.		
which requirement applies to you, then attach the appropriate		
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:		
g the training provided in platysmal muscle plication/similar		
icant performed, as primary or assistant surgeon, at least 10 similar procedures.		
<ul> <li>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:</li> <li>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.</li> </ul>		
e been obtained from one of the following: oral and maxillofacial surgery accredited by the Commission		
committee on Medical Education or other official accrediting sociation		
<ul> <li>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</li> <li>d. the American Medical Association, approved for category 1, continuing medical education.</li> </ul>		
m cosmetic surgical procedures within a hospital accredited Healthcare Organizations, or fully obscured, for at least 10 cases in platysmal muscle as the primary or secondary surgeon. At least 5 of the ten gned statement from the proctor that specifies the number of proctored.		