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

A completed application shall include the following unless stated below. An incomplete application or fee will delay the processing of your application. Incomplete applications are kept for one year then destroyed. All required documentation is to be sent to the Board in a single packet with the application. Please note: Fees are not refundable, regulation 18 VAC 60-20-40.

INSTRUCTIONS FOR REINSTATMENT OF LICENSE:

_____ **1. Reinstatement Application**. Please be sure that all information is completed on the application. The application can be used for one year from date of receipt.

_____ **2. Fee for applicant due to lapse of license** (Regulation 18 VAC 60-20-20.C.1): Any person whose license has expired who wishes to reinstate such license shall submit to the board a reinstatement application, reinstatement fee of $500 for dentists and $200 for dental Hygienists.

Fee for license previously revoked or indefinitely suspended (Regulation 18 VAC-20-20.D). Any person whose license has been revoked shall submit to the board for its approval a reinstatement application and fee of $1,000 for dentists and $500 for dental hygienists. Any person whose license has been indefinitely suspended shall submit to the board for its approval a reinstatement application and fee of $750 for dentists and $400 for dental hygienists.

Certified check, cashier's check or money order is made payable to the Treasurer of Virginia. Fee can be used for one year from date of receipt. A processing fee of $35 will be charged for any check or money order returned unpaid by your bank.

_____ **3. Form B**. Chronology listing **ALL** activities since receiving degree

_____ **4. Form C**. Certification of licensure not older than 6 months from each jurisdiction in which you hold or have ever held a license to practice dentistry. Copies of licenses or permits from other states are not accepted.

_____ **5**. **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) These two reports can be obtained from www.npdb-hipdb.hrsa.gov, 1-800-767-6732,** P.O. Box 10832, Chantilly, VA 20153-0832, copies are not acceptable). These reports should be submitted with the application

____ **6. Name Change**. Documentation must be provided to show each name changes(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.

_____ **7**. **Continuing Education**. (Regulation 18 VAC 60-20-50.H) A licensee who has allowed his license to lapse, or who has had his license suspended or revoked must submit evidence of completion of continuing education equal to the requirements for the number of years in which his license has not been active, not to exceed a total of 45 hours. Of the required hours, at least 15 must be earned in the most recent 12 months and the remainder within the 36 months preceding an application for reinstatement.

Please submit copies of continuing education which indicates:
(1) your name,
(2) name of course,
(3) date of course
(4) name of sponsor; and
(5) number of hours.

Any missing documentation will delay the processing of your application.

PLEASE NOTE:

- **In order to qualify for reinstatement of an expired license, the applicant must include documentation in the application sufficient to demonstrate continuing competence. Evidence shall include continuing education and may include evidence of active practice in another state or in federal service or current specialty board certification (Regulation 60.20.20.(3). Completion of home study, journal or internet courses is 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 updated/resubmitted.**

- **You might obtain the Virginia dental and dental hygiene laws and the regulations of the Virginia Board 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".**

- **After 15 business days of applying, you might check on-line to see if your license has been reinstated by going to 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.**

- **Documents submitted with an application are the property of the board and cannot be returned.**

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BOARD OF DENTISTRY
DEPARTMENT OF HEALTH PROFESSIONS
9960 Mayland Drive, Suite 300
Henrico, VA 23233-1463
804-367-4538
www.dhp.virginia.gov/dentistry

REINSTATEMENT APPLICATION

[ ] DENTAL LICENSE [ ] DENTAL HYGIENE LICENSE

INSTRUCTIONS: Use a typewriter or print clearly. If the space provided for any answer is insufficient, the applicant must complete his/her answer on a "rider" signed by him/her, specifying the number of the question to which it relates, and enclose it with this application. OMMISSIONS OR INACCURACIES MAY DELAY PROCESSING YOUR APPLICATION.

I. APPLICANT PROFILE DATA: PLEASE COMPLETE ALL SECTIONS (PRINT OR TYPE)				
Name:Last	First	Middle/Maiden		Suffix
Address of Record (Mailing Address)	City	State	Zip Code	Telephone Number
Publicly Disclosable Address	City	State	Zip Code	Telephone Number
Email Address		Fax		
Date of Birth _____/_____/_____		Social Security Number or Virginia DMV Control Number ____ ____ ____--____ ____ --____ ____ ____ ____		
Graduation Date	Degree	School City State		
License Number	Date of Expiration	Name at time of Original Licensure*		

[ ] REINSTATEMENT REQUESTED DUE TO LAPSE OF LICENSE
[ ] SUSPENSION
[ ] REVOCATION

FOR OFFICE USE ONLY

FEE AMOUNT	APPLICANT NUMBER	DATE OF REINSTATEMENT
FORM B	CERT.OF LIC/FORM C	NPDB _____ HIPDB _____

NOTE: 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 make available to the public, complete both sections with the same address.

***IF PROOF OF NAME CHANGE TO CURRENT NAME HAS NOT BEEN FILED WITH THIS OFFICE, SUBMIT A COPY OF THE MARRIAGE CERTIFICATE OR COURT ORDER AUTHORIZING THE CHANGE.**

II. APPLICANT HISTORY:

All Questions Must be Answered. If any of the questions are answered "Yes", explain and substantiate with available documentation. Letters must be submitted by your attorney regarding malpractice suites. Letters must be submitted by any treating professionals regarding treatment and shall include diagnosis.

a.	Have you every been dropped, suspended, expelled or disciplined by a school or college for any cause whatever? If yes, give details, school(s), address(es) and dates(s) on a separate page.	[ ] Yes	[ ] No
b.	Has your practice of dentistry/dental hygiene since expiration of your license been in the Commonwealth of Virginia? Is yes, give location._____	[ ] Yes	[ ] No
c.	Has any of your work since the expiration of your dental /dental hygiene license been in any field other than the practice of dentistry? If yes, give details, jurisdictions(s) and date(s). _____ _____ _____	[ ] Yes	[ ] No
d.	Have you ever announced yourself, or held yourself out, as being a specialist in any branch of dentistry? If yes, give specialty(ies) and jurisdictions_____ _____	[ ] Yes	[ ] No
e.	Have you ever been denied a license, or the privilege of taking a dental/dental hygiene licensure/competency examination by any licensing authority? If yes, give details, jurisdiction(s) and date(s)._____ _____ _____	[ ] Yes	[ ] No

f. List all jurisdictions in which 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	Expiration Date
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

g.	Have you ever failed the dental/dental hygiene licensing examinations given for another jurisdiction? If yes, give details, jurisdiction(s) and date(s)._____ _____ _____	[ ] Yes	[ ] No
h.	Have you ever been convicted of a violation of or pled Nolo Contender 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 deposition record certified by the Clerk of the Court.	[ ] Yes	[ ] No
i.	Have you ever voluntarily surrendered your clinical privileges while under investigation, been censured or warned, or been requested to withdraw from the staff or any hospital, nursing home, other health care facility, or any health care provider? If yes, give details, jurisdiction(s) and date(s) on a separate page.	[ ] Yes	[ ] No

j.	Have you ever voluntarily withdrawn from any professional society while under investigation? If yes, give details, jurisdiction(s) and date(s) on a separate page.	[ ] Yes	[ ] No
k.	Have you ever had any of the following disciplinary actions taken against your license to practice dentistry/dental hygiene, your DEA permit , Medicare, Medicaid or are any such actions pending; suspension/revocation, or probation, or reprimand/cease and desist or monitoring or practice, or limitation placed on scheduled drugs? If yes give details, jurisdiction(s) and date(s) on a separate page.	[ ] Yes	[ ] No
l.	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
m.	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
n.	Is there now, or has there ever been, in any jurisdiction, a complaint pending against your professional conduct or competence as a dentist/dental hygienist? If yes, give details, jurisdiction(s) and date(s) on a separate page.	[ ] Yes	[ ] No
o.	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
p.	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 case 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 summary of diagnosis, treatment and prognosis.	[ ] Yes	[ ] No
q.	Have you ever received treatment for, or been hospitalized for, a nervous, emotional or mental disorder? If yes, provide a letter of explanation from the treating professional(s), including summary of diagnosis, treatment and prognosis.	[ ] Yes	[ ] No
r.	Do you have a physical disability, disease, or diagnosis which could affect your performance of professional duties within the last five (5) years? 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 summary of diagnosis, treatment and prognosis.	[ ] Yes	[ ] No
s.	Have you ever been adjudged mentally incompetent, or been voluntarily or in voluntarily committed to a mental institution? If yes, give details, jurisdiction(s) and dates) on a separate page, and provide certified copies of all applicable court documents.	[ ] Yes	[ ] No

III. DOCUMENTATION REQUIRED

FORM B. Chronology. The complete, chronological history of your employment to be detailed on "Form B: Chronology." All time must be accounted for, whether applicant was employed or not. Include temporary or part-time employment, and resident addresses during periods of employment. You must especially account for all time during which your license has expired, whether employment was in the field of dentistry or not.

FORM C. Certification, Other Boards. A completed "Form C: Certification, Other Boards' documentation bearing certification of good standing from each state in which you currently or have ever held, a license to practice Dentistry or Dental Hygiene.

Continuing Education: Submit evidence of continuing education according to Regulation VAC 60-20-50.H.

All documentation is to be sent to the Board of Dentistry in a single packet with the application of reinstatement of license. Do not submit an incomplete application, or any single part of an application or documentation to the Board.

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

My commission expires on _____.

_____
Signature of Notary Public

SEAL

VIRGINIA BOARD OF DENTISTRY
9960 Mayland Drive,Suite 300
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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 year.

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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Department of Health Professions
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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:

[ ] Examination for Dental License
[ ] Examination for Dental Hygiene License
[ ] Reinstatement
[ ] Full Time Faculty
[ ] Credentials for Dental License
[ ] Endorsement for Dental Hygiene License
[ ] Teachers License
[ ] Registration for Volunteer

I, _____, was granted License Number _____

on _____19_____20_____ by the State of _____. The Virginia Board of Dentistry

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: Please complete and return this form to the applicant. If disciplinary action has been taken, return the form to the 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):_____

_____

Derogatory information, if any:_____

Comments, if any:_____

SEAL

_____ Signature

_____ Title

_____ Date

Revised May 21, 2010

NAME OF LICENSEE _____ LICENSE NUMBER _____

PLEASE LIST CONTINUING EDCATION BELOW COMPLETING
ALL INFORMATION AND INCLUDE ALL SUPPORTING DOCUMENTATION

(Refer to Regulation 18 VAC 60-20-50. Requirements for continuing education for approved sponsors)

DATE (in date order)	NAME OF COURSE	APPROVED SPONSOR	NUMBER OF HOURS	BOARD REVIEW

Revised May 21, 2010

TOTAL HOURS_____