COMMONWEALTH OF VIRGINIA
BOARD OF DENTISTRY

Department of Health Professions
9960 Mayland Drive, Suite 300
Henrico, VA 23233-1463
(804) 367-4538

ORAL AND MAXILLOFACIAL SURGEON
REGISTRATION OF PRACTICE

INSTRUCTIONS: Use typewriter or print clearly. If the space provided for any answer is insufficient, the registrant 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
Publicly Disclosable Address	**City**	**State**	**Zip code**	**Telephone Number**

Email Address	Fax #
Date of Birth ____ ____/____ ____/____ ____ ____ ____	Social Security Number or Virginia DMV Control Number ____ ____ ____--____ ____ --____ ____ ____ ____

Date of Completion of Residency	Name of Residency Program in Oral and Maxillofacial Surgery (must be approved by the Commission on Dental Accreditation of the American Dental Association). Please attach a copy of the certificate of completion:
_____/_____/_____	

Virginia Dental License Number	

Please check Yes or No for each of the following questions. If any of the following questions are answered "YES", please attach documentation.

	YES	NO
a. Have you ever been convicted of a crime?	_____	_____
b. Have you ever had an action taken against your license by another state board?	_____	_____
c. Have you ever had your hospital privileges revoked or suspended?	_____	_____

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

_____ _____
Signature of applicant Date

Please mail completed form and the required fee of $175 (check made payable to "Treasurer of Virginia") to:

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Board of Dentistry
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For office use only:				
Date Received	Fee	Pending #	Registration #	Date Issued

Revised Feb. 9, 2010