

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

REQUIREMENTS AND INSTRUCTIONS FOR A TEMPORARY RESIDENT'S LICENSE FOR PERSONS ENROLLED IN ADVANCED DENTAL EDUCATION PROGRAMS (§54.1.2711.1)

All of the following must accompany the enclosed application for licensure. An incomplete application and or fees could result in the delay of the processing or return of your application. Pursuant to Regulation 18 VAC 60-20-40, all fees are non-refundable.

- _____ **1. Licensure application.**
- _____ **2. Application Fee \$60.** Certified check, cashier's check or money order made payable to the Treasurer of Virginia
- _____ **3.. Form A or Original** documentation of graduation from a dental program is required. The school may use this form or its own form to meet this requirement. The certification must bear the school's seal or be on letterhead. (Faxed copies are not acceptable).
- _____ **4. Form B** from the dean of the dental school or dental program director specifying the applicant is accepted as an intern, resident or post doctoral certificate or degree candidate in an advanced dental education program. The beginning and ending dates of the internship, residency or post-doctoral program must be specified
- _____ **5. Form C-** (if applicable) Licensure verification from any jurisdiction in which you hold or have ever held a license to practice dentistry, copies of licensure permits are not accepted. Verification cannot be older than 6 months.
- _____ **6. Form D** (if applicable) - Chronology, follow instructions on form
- _____ **7. Original** grade card issued by the Joint Commission on National Dental Examinations. Original grade cards submitted by the applicant are accepted. Copies of grade cards are not accepted;
- _____ **8.** Original current reports, not older than 6 months from date prepared) obtained by self query to the (1) Healthcare integrity and Protection Data Bank (HIPDB) AND (2) National Practitioner Data Bank (NPDB). These two reports (combined as one report) are required from all applicants (Regulation 18VAC 60-20-100.3) and should be submitted with application.
- _____ **9. 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 and will remain current with the applicable Virginia dental and dental hygiene laws and regulations of the Virginia Board of Dentistry. A passport-type photo not older than 6 months is required.

_____ **10. Name Change.** Documentation must be provided to show each name change 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. Photocopies of marriage licenses or court orders are accepted.

This temporary license authorizes the licensee to perform patient care activities associated with the educational facilities owned or operated by, or affiliated with, the dental school or program. It does not authorize the practice of dentistry in nonaffiliated clinics or private practice settings.

The temporary license holder shall be responsible and accountable at all times to a licensed dentist, who is a member of the staff where the internship, residency or post-doctoral candidacy is served. The temporary licensee is prohibited from employment outside of the advance dental education program where a full license is required.

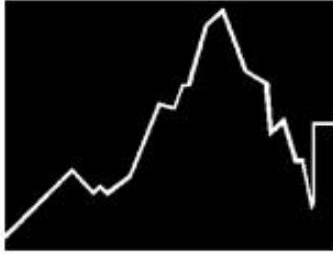
FYI

National Practitioner Data Bank (NPDB)
Healthcare Integrity and Protection Bank (HIPBD)
P.O. Box 10832
Chantilly, VA 20153-0832
1-800-767-6732
703-802-4109 FAX
www.npdb-hipdb.hrsa.gov

National Boards
American Dental Assoc.
Joint commission on Dental Examiners.
211 East Chicago Ave.
Chicago, IL 60611-2678.
312-44-2500
312-440-1915 FAX
www.ada.org

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 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 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 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.**
- **A Virginia address must be provided before a Temporary Resident’s License can be issued.**



Commonwealth of Virginia
 Board of Virginia
 Department of Health Professions
 9960 Mayland Drive, Suite 300
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 804-367-4538 www.dhp.virginia.gov/dentistrv

APPLICATION FOR TEMPORARY RESIDENT'S LICENSE

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.**

I. APPLICANT PROFILE: 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 ____/____/____ Month Day Year	Professional Degree	Dental School /City / State or Country	

APPLICANTS DO NOT USE SPACES BELOW THIS LINE – FOR OFFICE USE ONLY

Date Received	Chronology (Form D)	<input type="checkbox"/> Healthcare Integrity and Protection Bank <input type="checkbox"/> National Practitioner Data Bank	National Boards
FEE	APPLICANT #	LICENSE #	DATE ISSUED
Transcript	Certification (Education) Form A	Recommendation from dean/director (Form B)	Certification (License from other states) (Form C or Letter)

*Name change: Documentation must be provided to show name changes(s) if name has ever been 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 Security Number or your 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 for by law. Federal and state law requires that this number be shared with other agencies for child support enforcement activities.

- 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
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- e. 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
- f. 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
- g. 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
- h. 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
- i. 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
- j. Have you ever had any malpractice suits brought against you in the last ten (10) years? 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
- k. 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
- l. 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
- m. 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
- n. 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 A
Temporary Resident's License

COMMONWEALTH OF VIRGINIA
BOARD OF DENTISTRY
Department of Health Professions
9960 Mayland Drive, Suite 300
Henrico, VA 23233-1463
(804) 367-4538 www.dhp.virginia.gov/dentistry

CERTIFICATION OF DENTAL SCHOOL FOR TEMPORARY RESIDENT'S LICENSE

APPLICANT: ENTER YOUR NAME AND GRADUATION DATE BELOW THEN SEND THIS FORM TO THE DEAN OR DIRECTOR OF EACH DENTAL SCHOOL WHICH GRANTED YOU A DEGREE OR CERTIFICATE.

APPLICANT _____ GRADUATION DATE: _____

DEAN/PROGRAM DIRECTOR: Please provide certification that the applicant named above received a dental degree or certificate from your program. The certification may be provided by completing this form or by providing a letter with the information requested on this form. Either document must bear the school's seal. The certification should be returned to the APPLICANT. Certifications made prior to the applicant's graduation cannot be accepted.

NAME OF SCHOOL: _____

NAME OF PROGRAM: _____

PROGRAM'S CODA ACCREDITATION STATUS: _____

DEGREE or CERTIFICATION GRANTED: _____

DATE GRANTED: _____ / _____ / _____
Month Day Year

By affixing my signature below, I certify that the applicant named above is a graduate of a dental program.

Signature

(SEAL REQUIRED)

Title

Date

DEAN/REGISTRAR: Please provide the applicant an original, final transcript of this alumni record, to include courses, grades, degree or certificate received, and date the degree or certificate was conferred, which bears the certified signature of the registrar and has the college seal affixed.

Form B
Temporary Resident's License

COMMONWEALTH OF VIRGINIA
BOARD OF DENTISTRY
Department of Health Professions
9960 Mayland Drive, Suite 300
Henrico, VA 23233-1463
(804) 367-4538 www.dhp.virginia.gov/dentistry

MEMORANDUM:

TO: Virginia Board of Dentistry

FROM: Dean of dental school or the director of the accredited graduate program

Name of Training Institute: _____

Complete Mailing address: _____

Telephone: _____

This is to certify that _____ will be enrolled in _____
Name of resident Specialty

At _____, _____
Name of training facility Street Address

City, State and Zip Code

From _____ With an expected completion of date of _____
(Month/Day/Year) (Month/Day/Year)

Dr. _____ is a graduate of _____
Name of resident Dental School

Dean/Director

Signature

Form C

Temporary Resident's License

COMMONWEALTH OF VIRGINIA

BOARD OF DENTISTRY

Department of Health Professions

9960 Mayland Drive, Suite 300

Henrico, VA 23233-1463

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

CERTIFICATION OF DENTAL LICENSURE

Please forward one form to each state dental/dental hygiene board where you hold or have ever held a dental 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 a Temporary Residents License

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

