Virginia Department of Health Professions
Board of Dentistry

9960 Mayland Drive, Suite 300
Henrico, Virginia 23233
(804) 367-4538 (Tel)
(804) 698-4266 (eFax)
bodlicensing@dhp.virginia.gov
https://www.dhp.virginia.gov/Boards/Dentistry/

INSTRUCTIONS FOR A DENTAL LICENSE

There are **two** pathways for licensure in Virginia, **licensure by examination** or **licensure by credentials**. Read through the application instructions carefully before deciding which pathway to pursue. A completed application shall include the following unless otherwise stated below. An incomplete application and/or fee will delay the processing of your application. Incomplete applications remain active for one year from the date of receipt. After one year from date of receipt, you would need to reapply for Virginia licensure. Documents submitted with an application are the property of the Board of Dentistry and cannot be returned. If you need to receive approval to sit for a clinical exam, then you would need to use the pathway for licensure by examination application and select a testing agency to be approved.

You may view the status of the checklist items for your application by visiting the Online Applications website, creating an online account, log in with your User ID and Password, and clicking on the "**View Checklist**" link in the Pending Licenses section. Using the View Checklist feature will allow you to review which application items have been completed and which are still outstanding.

____ 1. **Application:** Please be sure that all information and questions are completed on the application.

____ 2. **Application Fee:** The fee for a **dental license by examination is $400** and the fee for a **dental license by credentials is $500**, which must be paid with a check or money order, made payable to **The Treasurer of Virginia**. The fee can be used for one year from date of receipt. Pursuant to 18VAC60-21-40(G), all fees are **non-refundable**. Your application will not be submitted to the Board of Dentistry for review until you have submitted your payment.

____ 3. **Form A Certification of Graduation (For Post-Doctoral Specialty Programs Only): Original** certification of graduation by each post-doctoral specialty dental school which granted you a dental degree or certificate from a dental program accredited by the Commission on Dental Accreditation of the American Dental Association (CODA) or the Commission on Dental Accreditation of Canada (CDAC), at least a 12-month post-doctoral advanced general dentistry program or a post-doctoral dental education program of at least 24 months that includes a **clinical component**.

Applicants must submit a Form A for **each** degree and/or certificate earned from a post-doctoral specialty dental program accredited by CODA or CDAC. The school may use this form or its own form to meet this requirement.

The certification form must bear the school's seal or be on letterhead bearing the school's seal and must include the program's CODA/CDAC accreditation status at the time you completed the program. This information is only accepted from programs accredited by CODA or CDAC. **Note**: This form will be required if you completed a post-doctoral specialty program for confirmation of specialty if your specialty is used to document clinical practice.

(Options: Mail to the Board (address listed above), or the school/agency **official** representative may email the documentation to bodlicensing@dhp.virginia.gov. Faxed copies are not acceptable.)

Documentation from foreign countries non-accredited CODA/CDAC schools' programs is not required and will not be considered.

____ 4. **Official Transcript:** Final **original** transcript bearing SEAL, date degree received (conferred date) and registrar's signature. Copies of transcripts, certificates and diplomas are not acceptable. If you completed a post-doctoral program at a hospital which does not maintain transcripts, a dated detailed letter (on official letterhead) that addresses the coursework and clinical training that you completed, signed by the Program Director, is required.

(Options: Mail to the Board (address listed above) or the school, e-scrip, or parchment services provider may directly email the transcript information to bodlicensing@dhp.virginia.gov.)

Note: An official transcript –must be on original official school paper (sealed) or an online version that Board staff must download from the school, e-scrip, or parchment services website. **Documentation from foreign countries non-accredited CODA/CDAC schools' programs is not required and will not be considered.**

5. **Form C License Verification: Original** licensure status and certification from every jurisdiction in which you currently hold or have ever held a license/registration/certification to practice as a dentist or as another health care professional. Copies of permits are not accepted. Certifications cannot be older than 6 months from date prepared.

   (Options: Mail to the Board (address listed on page 1) or have the issuing state official state representative email the verification directly to bodlicensing@dhp.virginia.gov. If the issuing state/jurisdiction (agency) does not provide an original document, then the applicant must provide/submit the issuing agency statement as to why the issuing agency does not provide verification and submit a copy of the electronic version from the issuing agency website to the Board using either option.)

   Documentation from foreign countries is not required and will not be considered.

6. **Clinical Scores:** An **original** (meaning 1 because score cards cannot be combined) detailed score card or report from a Board Approved testing agency documenting passage of a clinical competency examination; meaning a formal test of knowledge and competence in the evaluation, diagnosis, and treatment of dental conditions and the prevention of dental diseases which includes live patient and/or manikin based testing methods to demonstrate the skills needed to safely provide care and treatment of patients, is required.

   Candidate's score cards are not acceptable. ***All score cards or reports must be requested by the applicant***. (Canadian exams are not accepted.) Certificates are not accepted. (Options: Mail to the Board (address listed on page 1) or have the testing agency official representative email the score report directly to bodlicensing@dhp.virginia.gov, or if applicable, you contact the testing agency and request your test results be made available to the Virginia Board of Dentistry via their online access portal.)

   See Guidance Document 60-25 Policy On Dental Clinical Competency Examination Requirements for Licensure, for both application by examination and credentialing for complete details. The Board does not accept exams that do compensatory scoring, it is the applicant's responsibility to check with their testing agency about compensatory scoring.

   If applying by examination: Applicants who successfully completed a clinical competency examination five or more years prior to the date of receipt of their applications for licensure by this board would be required to provide one of the three documentation options

   1. retake a board-approved examination (original copy of exam scores)
   2. take board-approved clinical continuing education as evidence of continuing competence that meets the requirements of 18VAC60-21-250 (copy of completed coursework certificate or transcript that shows the percentage of clinical hands-on training)
   3. submit documentation that you have maintained clinical, ethical, and legal practice in another jurisdiction of the United States or in federal civil or military service for 48 of the past 60 months **immediately prior** to submission of an application for licensure. (May use our employment of verification form on page 13 to document employment.)

   For example, the five-year period immediately preceding an application received on May 5, 2023, began on May 6, 2018. The six calendar years for this example application are:

   First year: May 6, 2018, to May 5, 2019.
   Second year: May 6, 2019, to May 5, 2020.
   Third year: May 6, 2020, to May 5, 2021.
   Fourth year: May 6, 2021, to May 5, 2022.
   Fifth year: May 6, 2022, to May 5, 2023, and

   Note: It is the applicant's responsibility to prove clinical competency (see guidance document 60-12).

   Approval to take a clinical examination will only be granted to applicants who are otherwise eligible for an **unrestricted license** as documented in a **completed application.** Approval will not be granted to applicants who do not hold a diploma or certificate from a dental program accredited by CODA or CDAC, as required by §54.1-2709.B (ii) of the Code of Virginia and by 18VAC60-21-200 of the Regulations Governing the Practice of Dentistry. You would need to satisfy all licensure requirements other than having completed an acceptable clinical exam; therefore, you would indicate on the application the exam-testing agency you would like to be approved to sit/take a clinical exam.)

   If applying by credentials: See the additional requirements in numbers 12, 13, and 14 before selecting this pathway.

7. **NBDE:** An **original** grade card **showing passage of all parts of the National Board Dental Examination** issued by the Joint Commission on National Dental Examinations is required. Copies of grade cards are not accepted . (You must contact the testing agency to request that your test results be made available to the Virginia Board of Dentistry via their online access portal and then notify the Board when it is available.)

8. **NPDB:** An **original** current report, not older than 6 months from date prepared, must be obtained by Self Query from the National Practitioner Data Bank (NPDB), which may be requested through their website at www.npdb.hrsa.gov. There is a fee for this report. ***This report from NPDB is required from all applicants, without exception*** *(Regulation 18VAC60-21-190.3)**.***

9. Please be aware that your electronic signature authorizes the release of confidential information, affirms that your application is complete and correct, and attests that you have read, understand, and will remain current with the laws and regulations governing the practice of dentistry in Virginia. Review the laws and regulations via the "Laws and Regulations" tab at: http://www.dhp.virginia.gov/Boards/Dentistry/PractitionerResources/LawsRegulations/.

10. **Legal/Name Change:** Documentation must be provided to show each name change if your name has ever been changed since graduation from a CODA or CDAC accredited program or were licensed in other jurisdictions **or other than what is listed on your application**. Photocopies of marriage licenses or court orders are accepted.

11. **Address of Record and Publically Disclosable Address:** 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.

Additional requirements for licensure by credentials which is *the pathway to licensure for an applicant who holds a license in another state, who passed a clinical competency exam referenced for acceptance for licensure by examination in number 6 above, and who has recently practiced dentistry for at least 5 years. The applicant is* **additionally** required to:

12. **Form B Chronology:** List ALL personal and professional activities, to include all time periods of employment and unemployment, since receiving your doctoral degree or post- doctoral advanced certification. *(Resumes and curriculum vitae are not accepted as substitutes for completing the chronological listing on Form B and will not be considered*

13. Hold a current, unrestricted license to practice dentistry in another jurisdiction in the United States which was obtained by successfully passing a clinical competency examination comparable to the exam required by the Commonwealth of Virginia and are certified to be in good standing by each jurisdiction in which you currently hold or have held a license.

14. Provide the Number of Hours of clinical practice for each dental position held within the six-year period prior to applying. Hours must be reported per calendar year. To qualify for licensure by credentials the applicant must have practiced a minimum of 600 hours in each of five calendar years during the six years immediately preceding your application. The Board counts back six years from the date of receipt of an application.

    For example, the six-year period immediately preceding an application received on May 5, 2023, began on May 6, 2017. The six calendar years for this example application are:

First year:	May 6, 2017, to May 5, 2018.
Second year:	May 6, 2018, to May 5, 2019.
Third year:	May 6, 2019, to May 5, 2020.
Fourth year:	May 6, 2020, to May 5, 2021.
Fifth year:	May 6, 2021, to May 5, 2022, and
Sixth year:	May 6, 2022, to May 5, 2023.

Additional requirements for Oral and Maxillofacial Surgeons (Code §54.2709.1 and 2) Prior to practicing as an oral and maxillofacial surgeon, you are required to register with the Board of Dentistry (see Regulation 18VAC60-21-310). You are also required to obtain certification before performing certain cosmetic procedures (see Regulation 18VAC60-21-350). The applications for registration and certification are available at Virginia Board of Dentistry- Oral Maxillofacial Surgeon or you may request the forms by calling the Board office at (804) 367-4538. Once you are registered with the Board, you will receive instructions for completing a profile of information about your practice for the public.

NOTES:

- Completed applications cannot be accessed or edited once they have been submitted.
- If your Virginia License is not issued within 6 months of the date of the NPDB (National Practitioner Databank) Self Query Report and certification of state licensure, then you will be asked to submit a current NPDB Self Query Report and current state licensure certification before your application can be reviewed for approval.
- **DEA Registration:** Applicants must have a dental license prior to applying for a DEA License. Requests for an application in Virginia should be made to the following: Drug Enforcement Administration, Attn: Registration Section/ODR, P.O. Box 2639, Springfield, VA 22152-2639; 1-800-882-9539; www.deadiversion.usdoj.gov
- To receive notice that your supporting documents have been delivered to the Board, it is suggested that the documents be mailed using Fed-Ex or UPS with "Delivery Confirmation". **Mail sent by USPS is sent to a separate state processing facility that is offsite; therefore, mail can be delayed. Note: if you send something certified by USPS it only verifies that it got to the processing facility and not the Board.**
- The Board does not have reciprocity with any other jurisdiction and cannot grant requests for exceptions to the policies, laws, or regulation nor predetermine acceptance of any documentation prior to the receipt of a complete application.
- Applicant will be notified of missing application items within approximately 15 business days from receipt of an application. Once your application is deemed complete, allow 30 business days processing time.

Related contact information:

Clinical Testing Agencies

CDCA (formerly NERB)
The Commission on Dental Competence Assessments
(formerly North East Regional Board)

WREB*
Western Regional Examining Board

Is now CDCA-WREB-CITA

1304 Concourse Dr, Suite 100
Linthicum, MD 21090
Phone: 301-563-3300
Fax: 301-563-3307
https://adextesting.org/

CITA
Council of Interstate Testing Agencies

SRTA
4698 Honeygrove Road, Suite 2
Virginia Beach, VA 23455
Phone: 757-318-9082
Fax: 757-318-9085
www.srta.org

CRDTS*
1725 SW Gage Blvd
Topeka, KS 66604
Phone: 785-273-0380
Fax: 785-273-5015
www.crdts.org

*The Board does not accept exams that do compensatory scoring, it is the applicant's responsibility to check with their testing agency about compensatory scoring.

National Board

Joint Commission on National Dental Examinations (NBDE)
211 East Chicago Avenue
Chicago, IL 60611-2678
Phone: 1-800-232-1694
https://jcnde.ada.org/

Effective November 30, 2016, the National Board Dental Examination (NBDE) result reports will no longer be sent via mail.

General Information

National Practitioner Data Bank
P.O. P.O. Box 10832
Chantilly, VA 20153
1-800-767-6732
www.npdb.hrsa.gov

Where to Confirm Approved Programs
ADA (American Dental Association)
CODA (Commission on Dental Accreditation)
211 East Chicago Avenue
Chicago, IL 60611-2678
1-800-621-8099 or 312-440-4653
https://www.ada.org/en/coda

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APPLICATION FOR LICENSE TO PRACTICE DENTISTRY Page 1

Check only the box that applies:
[ ] **BY EXAMINATION** [ ] **BY CREDENTIALS**

INSTRUCTIONS: Type or print clearly. Complete all sections. If the space provided for any answer is insufficient, complete your answer on a separate page, specify the number of the question to which it relates, sign the page, and enclose it with the application.

I. GENERAL INFORMATION: COMPLETE ALL SECTIONS (PRINT OR TYPE)

Name: Last*	First	Middle/Maiden	Suffix

Address of record (Mailing Address)	City	State	Zip Code	Telephone Number
Publically Disclosable Address	**City**	**State**	**Zip Code**	**Telephone Number**

Email Address	Fax#

Date of Birth	**Social Security Number or Virginia DMV control Number****
_____/_____/_____ Month Day Year	____ ____ ____---____ ____--____ ____ ____ ____

DDS/DMD GRADUATION DATE	PROFESSIONAL DEGREE	CODA/CDAC APPROVED DENTAL SCHOOL/CITY/STATE
_____ _____ _____ Month Day Year		
RESIDENCY/SPECIALTY GRADUATION DATE _____ _____ _____ Month Day Year	RESIDENCY/SPECIALTY DEGREE or CERTIFICATE	CODA/CDAC APPROVED DENTAL SCHOOL/CITY/STATE

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

DATE RECEIVED	CHRONOLOGY (FORM B)	NATIONAL PRACTITIONER DATA BANK	NATIONAL BOARD

TRANSCRIPT	CERTIFICATION (EDUCATION) (FORM A)	CERTIFICATION (LICENSE FROM OTHER STATES) (FORM C OR LETTER)

SRTA	CDCA-WREB-CITA (CDCA (formerly NERB), WREB & CITA merged in August 2022)	CRDTS	STATE

***Name change: Documentation must be provided to show name change(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 by law. Federal and state law requires that this number be shared with other agencies for child support enforcement activities.**

FEE AMOUNT	APPLICANT #	LICENSE #	DATE ISSUED

II. ALL EXAMINATIONS: ~~A~~nswer all questions "1" through "9"

1. Southern Regional Testing Agency (SRTA) –Exam Site _____ _____/_____/_____ Month/ Day / Year
   [ ] Passed [ ] Failed [ ] Never Taken [ ] Taken more than once (attach explanation)

2. Western Regional Examining Board (WREB) –Exam Site _____ _____/_____/_____ Month/ Day / Year
   [ ] Passed [ ] Failed [ ] Never Taken [ ] Taken more than once (attach explanation)

3. North East Regional Board (NERB/CDCA) –Exam Site _____ _____/_____/_____ Month/ Day / Year
   [ ] Passed [ ] Failed [ ] Never Taken [ ] Taken more than once (attach explanation)

4. Central Regional Dental Testing Services, Inc. (CRDTS) –Exam Site_____ _____/_____/_____ Month/ Day / Year
   [ ] Passed [ ] Failed [ ] Never Taken [ ] Taken more than once (attach explanation)

5. Council of Interstate Testing Agencies, Inc. (CITA) –Exam Site_____ _____/_____/_____ Month/ Day / Year
   [ ] Passed [ ] Failed [ ] Never Taken [ ] Taken more than once (attach explanation)

6. CDCA-WREB-CITA (ADEX) –Exam Site_____ _____/_____/_____ Month/ Day / Year
   [ ] Passed [ ] Failed [ ] Never Taken [ ] Taken more than once (attach explanation)

7. State of _____ –Exam Site_____ _____/_____/_____ Month/ Day / Year
   [ ] Passed [ ] Failed [ ] Never Taken [ ] Taken more than once (attach explanation)

8. National Board Examination: (Original grade cards are required) _____/_____/_____ Month/ Day / Year
   [ ] Passed [ ] Failed [ ] Never Taken [ ] Taken more than once (attach explanation)

9. [ ] Never Taken a clinical examination (attach explanation)

The Board must receive an original score card or report from the testing agency for each examination reported above. See the Application Instructions #6 and #7 for more details.

III. EXAMINATION(S) APPROVAL: Indicate by checkmark if you need Board approval to take the following exam:

CDCA-WREB-CITA (ADEX) [ ]

IV. APPLICANT HISTORY: ALL QUESTIONS MUST BE ANSWERED.

If any of the following questions are answered "YES", explain, and substantiate with documentation. Letters must be submitted by your attorney regarding malpractice suits. Letters must be submitted by any treating professionals regarding health treatment and shall include diagnosis, treatment, and prognosis.

1. Are you relocating to Virginia or an adjoining state or the District of Columbia with a spouse who is 1) on federal active-duty orders, or 2) a veteran who has left active-duty service within one year of submission of this application? If "YES", include a copy of the official military orders with the application. [ ] Yes [ ] No

2. Are you active-duty military? If "YES", include a copy of your official military orders with the application. [ ] Yes [ ] No

3. List in chronological order including months and years, the dental school(s) attended (include specialty and advanced programs):

Months & Years	Name of Dental School (ADA-CODA)	Passed/Failed
_____ to _____	_____	_____
_____ to _____	_____	_____
_____ to _____	_____	_____

4. List all jurisdictions in which you currently hold or have ever held a license/registration/certification to practice as a dentist or as another health care professional.

Jurisdiction	Number	Type	Date Issued	Exp. Date
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

5. 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). Please note: the Board may ask for additional documentation. [ ] Yes [ ] No

_____

_____

6. Have you ever been denied a license, or the privilege of taking a dental licensure/competency examination by a licensing authority? If "YES", give details, jurisdiction(s), and date(s) on a separate page. Please note: the Board may ask for additional documentation. [ ] Yes [ ] No

_____

_____

7. Have you ever been convicted of a violation or plead Nolo Contendere, 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.) "Additionally, any information concerning an arrest, charge, or conviction that has been sealed, including arrests, charges, or convictions for possession of marijuana, do not have to be disclosed." [ ] Yes [ ] No

   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. Please note: the Board may ask for additional documentation.

_____

_____

8. 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, jurisdiction(s), and date(s) on a separate page. Please note: the Board may ask for additional documentation. [ ] Yes [ ] No

_____

_____

9. 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. Please note: the Board may ask for additional documentation. [ ] Yes [ ] No

_____

_____

10. 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. Please note: the Board may ask for additional documentation. [ ] Yes [ ] No

_____

_____

11. 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. Please note: the Board may ask for additional documentation. [ ] Yes [ ] No

_____

_____

12. Have you had any malpractice suits brought against you in the past ten (10) years? [ ] Yes [ ] No

If "YES", please provide details for each pending or closed case, list additional claim(s) on a separate page and provide a letter from your attorney explaining each case. Please note: the Board may ask for additional documentation.

Claimant:_____ Date of Incident_____

Name of Defense Attorney:_____

Settlement or Verdict Amount:_____

Name of Involved Insurance Company:_____

Brief description of the claim:_____

_____

_____

ADDITIONAL LICENSURE QUESTIONS:

1. Do you have any reason to believe that you would pose a risk to the safety or well-being of your patients or clients? If "YES", please provide a full explanation and supporting documentation to the Board. Please note: the Board may ask for additional documentation. [ ] Yes [ ] No

_____

_____

2. Are you able to perform the essential functions of a practitioner in your area of practice with or without reasonable accommodation? If "NO", please provide a full explanation and supporting documentation to the Board. Please note: the Board may ask for additional documentation. [ ] Yes [ ] No

_____

_____

3. Have you ever been disciplined by any entity? If "YES", please provide a full explanation and supporting documentation to the Board. Please note: the Board may ask for additional documentation. [ ] Yes [ ] No

_____

_____

4. Have you ever had any conditions or restrictions been imposed upon you or your practice to avoid disciplinary action by any entity? If "YES", please provide a full explanation and supporting documentation to the Board. Please note: the Board may ask for additional documentation. [ ] Yes [ ] No

_____

_____

5. Are you currently practicing in Virginia on a 90-day temporary basis under Virginia Code § 54.1-2408.4? [ ] Yes [ ] No

If "YES", you must submit a completed out-of-state practitioner reporting form (pages 14-15) to document your place of employment.

VIRGINIA BOARD OF DENTISTRY
APPLICATION AFFIDAVIT

I hereby certify that I am the person referred to in the forgoing application and the attached supporting documents and that the information on this application and in the attachments is true, complete, and correct to the best of my knowledge.

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 http://www.dhp.virginia.gov/Boards/Dentistry/PractitionerResources/LawsRegulations/, and

I have attached a 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.

_____ _____

Applicant Signature Date

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Board of Dentistry

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FORM A
CERTIFICATION OF DENTAL SCHOOL
Post-Doctoral Specialty Programs ONLY

Applicant: Enter **only** your name and graduation date below, and then send this form to the Dean or Director of each Dental School or Program, 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 and certification that the program completed was accredited by the Commission on Dental Accreditation of the ADA (CODA) or the Commission on Dental Accreditation of Canada (CDAC) at the time the applicant completed the program. The certification may be provided by completing this form or by providing an official detail letter with all the information requested on this form. Either document must bear the school's seal.

Certifications made prior to the applicant's graduation cannot be accepted.

NAME OF SCHOOL: _____

NAME OF PROGRAM:_____

PROGRAM'S CODA/CDAC ACCREDITATION STATUS ON THE DATE THE DEGREE OR CERTIFICATION WAS GRANTED:

A1:	Approval (without reporting requirements)	[ ]
A2:	Approval (with reporting requirements)	[ ]
IA:	Initial accreditation	[ ]
DIS:	Accreditation voluntarily discontinued	[ ]
WDRN:	Accreditation withdrawn	[ ]
X:	Intent to withdraw accreditation	[ ]
T:	Program is in Teach-Out by institution	[ ]
NE:	Required period of non-enrollment	[ ]

DEGREE or CERTIFICATION GRANTED:_____

DATE DEGREE or CERTIFICATION GRANTED: _____/_____/_____
Month Day Year

By affixing my signature below, I certify that the applicant named above is a graduate and a holder of a diploma or a certificate from a CODA/CDAC accredited dental program.

SEAL

_____
Signature

_____
Print Name

_____
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.

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FORM B
CHRONOLOGY
ONLY APPLICABLE TO LICENSURE BY CREDENTIALS
(Or LICENSURE BY EXAMINATION IF EXAM WAS COMPLETED OVER 5 YEARS)

APPLICANT NAME:_____

Every applicant must provide a complete chronological, personal, and professional history of all activities you have engaged in since receiving your degree or certification, including teaching positions, all periods of non-professional activity or employment, volunteer work and all periods of unemployment. **Curriculum vitae and resumes are not accepted as substitutes for completing the chronological listing and will not be considered.**

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 calendar year, i.e., 600 hours in 2004 or 1000 hours each year for 2001 - 2004.

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 Clinical Practice Hours Per Year**

Virginia Department of Health Professions
Board of Dentistry

9960 Mayland Drive, Suite 300
Henrico, Virginia 23233
(804) 367-4538 (Tel)
(804) 698-4266 (eFax)
bodlicensing@dhp.virginia.gov
https://www.dhp.virginia.gov/Boards/Dentistry/

FORM C
CERTIFICATION OF DENTAL 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
[ ] Credentials for Dental License
[ ] Dental Faculty License
[ ] Dental Temporary Permit
[ ] Examination for Dental Hygiene License
[ ] Credentials for Dental Hygiene License
[ ] Dental Hygiene Faculty License
[ ] Dental Hygiene Temporary Permit
[ ] Dental Restricted Volunteer License
[ ] Dental Hygiene Restricted Volunteer License
[ ] Dental Reinstatement
[ ] Dental Hygiene Reinstatement

I, was granted License Type/Number _____, on _____ by the State of
Month Date Year

_____. The Virginia Board of Dentistry requires that I submit evidence of the status of my license. You are hereby authorized to release any information in your files, favorable or otherwise directly to the **Virginia Board of Dentistry** at **9960 Mayland Drive, Suite 300, Henrico, Virginia 23233** or **bodlicensing@dhp.virginia.gov**. Your early attention is appreciated.

_____ _____ _____
Applicant's Signature Applicant's Typed/Printed Name Applicant's Address

_____

Executive Officer of the Board: please send this form directly to the Virginia Board of Dentistry.

State of _____ Name of Licensee_____ License #_____

Graduate of_____ License Type_____ Issued_____

By: [ ] Examination* [ ] Credentials [ ] Reciprocity with the State of _____ [ ] Endorsement with the State of _____

*If licensed by a state administered examination, please provide a scorecard or report, which shows that testing included live patients.

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):_____

_____

_____

Comments, if any:_____

_____

SEAL

_____ _____ _____
Signature Title Date

_____
Print Name

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EMPLOYMENT VERIFICATION

(MUST BE COMPLETED BEFORE A NOTARY PUBLIC)

Name of Employing Dentist(s) or Agency:_____

Complete Mailing Address: _____

Telephone Number:_____ Fax Number:_____

Email Address_____

"I, _____ DDS / DMD / agency representative,
(Print name & Title of the Employing Dentist or Agency Representative)

certify that _____, was employed by me in the clinical, ethical, and legal
(Print Applicant/Employee Name)

practice of a _____ from _____/____/_____ to _____/____/_____.
(Print Job Title) **Month Day Year** **Month Day Year**

_____ _____
Dentist's/Agency Representative Signature Date

State of _____

County/City of _____

Sworn and subscribed to, before me, this _____day of _____, _____
Day Month Year

My commission expires on _____.
Month Day Year

_____
Signature of Notary Public

SEAL/STAMP

_____
Print Name

Virginia Department of
Health Professions

Out-of-State Practitioner Reporting Form

Virginia Code § 54.1-2408.4, enacted by Chapter 464 of the 2022 Acts of Assembly, permits health care practitioners licensed, certified, or registered in another state or the District of Columbia to temporarily practice in the Commonwealth for 90 days provided certain provisions are met. These individuals may **only** practice temporarily for 90 days after receiving an offer of employment or contract for services from: **(1) a hospital licensed by the Virginia Department of Health, (2) a nursing home, (3) a dialysis facility, (4) the Virginia Department of Health, or (5) a local health department.**

****Any practitioner licensed in a profession which utilizes a compact that Virginia and the practitioner's state of licensure are parties to, should only practice in Virginia using a compact privilege for that profession.****

Eligible employers and contract service recipients **must fill out** the below information and submit to the applicable Board **before the practitioner begins temporarily practicing in Virginia**.

Complete all fields below:

Facility Name: _____

Address: _____ _____ _____ _____
Street City State Zip

Facility designation: ☐**Licensed hospital** ☐**Nursing home** ☐**Dialysis Facility**

☐**VA Dept. of Health** ☐**Local health dept.**

Facility POC: _____ _____ _____
Name **Phone Number** **24 Hour Phone Number**

E-mail: _____

By signing below, I certify that I or my facility has obtained a report from the National Practitioner Data Bank ("NPDB") for all individuals listed on this form subject to NPDB reporting.

_____ _____
Facility POC Signature Date

Practitioner's Name	License Type	State of License	License Identification Number	Estimated Start date for employment or contract services

Please submit all pages of this form to [bodlicensing@dhp.virginia.gov].