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 REINSTATEMENT OF DENTAL LICENSE

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.

__ 1. **Reinstatement Application:** Please be sure that all information is completed on the application. . Not answering all questions and supplying all information will result in a delay of your application. Also, if there are discrepancies in your application, then the Board may ask for additional clarification. Please note that every reinstatement application is sent to Enforcement for an investigation. An investigator from DHP, not an employee of the Board, will be contact with you. You can learn more about the process here, if license was revoked or suspended.

__ 2. **Application Fee**: **Lapsed** Dental License reinstatement fee is $500.00
Previously **Revoked** Dental License reinstatement fee is $1,000.00
Previously **Suspended** Dental License reinstatement fee is $750.00

The fee must be paid with a check or money order, made payable to the **Treasurer of Virginia** and is valid for one year from the date of receipt. Pursuant to 18VAC60-21-40(G), all fees are non-refundable. Your application will not be reviewed until you have submitted payment.

__ 3. **Form B Chronology:** List **ALL** activities since expiration of your license. *Resumes and curriculum vitae are not accepted as substitutes for completing the chronological listing and will not be considered.*

__ 4. **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. Not disclosing all license/registration/certification ever held as a dentist or as another health care professional, will result in your application being sent to Enforcement for an investigation.

(Options: Mail to the Board (address listed above) 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.

__ 5. **Continuing Education:** You must submit documentation of having completed 15 hours of continuing education (CE) for each year the license was lapsed, up to a total of 45 hours in the 36 months immediately preceding the application for reinstatement. Course sponsors and content must meet the requirement in 18VAC60-21-250 of the Regulations Governing the Practice of Dentistry. Of the required hours, at least 15 must be earned in the most recent 12 months immediately preceding your application and the remainder within the 36 months immediately preceding the application. Original documents or copies are accepted.

For example, the three period immediately preceding an application received on June 5, 2023, began on June 6, 2020. The three calendar years for this example application are:

First year:	June 6, 2020 to June 5, 2021
Second year:	June 6, 2021 to June 5, 2022
Third year:	June 6, 2022 to June 5, 2023

Submitted CE documentation **must** include the following:

- Your name
- Name of course completed

- If the subject matter of the course is not evident in the title, you must also submit the sponsor's course description.
- Date(s) in which you completed the course
- Name of the course sponsor; and
- The number of CE credit hours earned

__ 6. **NPDB:** A 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)**.***

__ 7. **Documentation of Continuing Competency:** the Board shall consider (i) hours of continuing education that meet the requirements of subsection H of 18VAC60-21-250; (ii) evidence of active practice in another state or in federal service; (iii) current specialty board certification; (iv) recent passage of a clinical competency examination accepted by the board; or (v) a refresher program offered by a program accredited by the Commission on Dental Accreditation of the American Dental Association. (See guidance document 60-12 for additional information.) Our employment verification form on page 10 may be used to document active clinical practice.

__ 8. Please be aware that your signed application affidavit 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/.

__ 9. **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.

__ 10. **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.

Notes:

- If your Virginia License is not reinstated 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 approved.

- To receive notice that your supporting documents have been delivered to the Board, it is suggested that the documents be mailed using FedEx 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.**

- Applicants will be notified via email of missing application items within approximately 15 business days of receipt of an application. Once your application is complete, allow 30 business days processing time.

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APPLICATION FOR REINSTATEMENT OF DENTAL LICENSE

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 Number:
Date of Birth _____/_____/_____ Month Day Year	Social Security Number or Virginia DMV Control Number on record** ____ ____ ____--____ ____ --____ ____ ____ ____

License Number	Date of Expiration	Name at time of Original Licensure:*

Please check below, if applicable:

☐ REINSTATEMENT REQUESTED DUE TO LAPSE OF LICENSE

☐ REINSTATEMENT REQUESTED DUE TO SUSPENSION

☐ REINSTATEMENT REQUESTED DUE TO REVOCATION

***Name change:** **Documentation must be provided to show name change(s) if name has ever been changed from the time you were licensed in Virginia or 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.**

FOR OFFICE USE ONLY

FEE AMOUNT	APPLICANT #	DATE OF REINSTATEMENT	LICENSE #

II. 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. Have you practiced dentistry since the expiration of your license in the Commonwealth of Virginia or in another jurisdiction? If "YES", give location(s)._____ [ ] Yes [ ] No

4. Has any of your work since the expiration of your dental license been in any field other than the practice of dentistry? If "YES", give details, jurisdictions(s) and date(s). [ ] Yes [ ] No

_____

_____

5. List all jurisdictions in which you currently hold or have ever held a license / registration / certification to practice dentistry or as any other health care professional:

Jurisdiction	License Number	Date Issued	Expiration Date

6. Have you ever been convicted of a violation of or pled Nolo Contendere 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.) "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." 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. [ ] Yes [ ] No

_____

_____

7. 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

_____

_____

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 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

_____

_____

10 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

_____

_____

11. Have you had any malpractice suits brought against you in the past ten (10) years?
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.

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

_____

_____

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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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 the expiration of your license, 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.**

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 #**

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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	[ ] Examination for Dental Hygiene License	[ ] Dental Restricted Volunteer License
[ ] Credentials for Dental License	[ ] Credentials for Dental Hygiene License	[ ] Dental Hygiene Restricted Volunteer License
[ ] Dental Faculty License	[ ] Dental Hygiene Faculty License	[ ] Dental Reinstatement
[ ] Dental Temporary Permit	[ ] Dental Hygiene Temporary Permit	[ ] Dental Hygiene Reinstatement

I, was granted License 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_____

Graduate of_____ License #_____Issued_____

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

*If licensed by a state administered examination, please provide a score card 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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NAME OF LICENSEE: _____ **LICENSE NUMBER:** _____

VIRGINIA BOARD OF DENTISTRY CONTINUING EDUCATION COURSES

Complete all information and **include** all required supporting documents.

Pursuant to *18VAC60-21-250(B)* of the **Regulations Governing the Practice of Dentistry,** CE programs shall be clinical courses in dentistry or dental hygiene or supportive of clinical services. Courses not acceptable include, but are not limited to estate planning, financial planning, investments, business management, marketing & personal health.

DATE	NAME OF COURSE	APPROVED SPONSOR	NUMBER OF EARNED HOURS	BOARD REVIEW

TOTAL HOURS_____

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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, _____ D.D.S./D.M.D./agency representative,
(Print name & Title of the Employing Dentist or Agency Representative)

certify that _____, was employed by me as a _____
(Print Applicant/Employee Name) **(Print Job Title)**

_____ from _____/____/_____ to _____/____/_____, in the clinical, ethical, and legal
Month Day Year Month Day Year

practice of a _____.

_____ _____
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