Virginia Department of Health Professions
Board of Dentistry

9960 Mayland Drive, Suite 300
Henrico, Virginia 23233
(804) 367-4538 (Tel)
(804) 698-4266 (eFax)
denbd@dhp.virginia.gov
www.dhp.virginia.gov/dentistry

INSTRUCTIONS FOR REINSTATMENT OF CERTIFICATION TO PERFORM COSMETIC PROCEDURES

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. You should know and understand the laws in Virginia regarding Certification to perform cosmetic procedures before completing the application. Read the provisions for certification, **Part VII, 18VAC60-21-350** through **18VAC60-21-400**.

In order for an oral and maxillofacial surgeon to perform aesthetic or cosmetic procedures, he shall be certified by the board pursuant to § 54.1-2709.1 of the Code. Such certification shall only entitle the licensee to perform procedures above the clavicle or within the head and neck region of the body based on the licensee education, training, and experience, certification.

____ 1 Hold an active unrestricted dentist license from the Board.

____ 2. **Application:** Please be sure that all information and questions are completed on the application.

____ 3. **Application Fee:** The fee for a **Certification to Perform Cosmetic Procedures is $225** and 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 reviewed until you have submitted payment.

____ 4. **Documentation of continued competency:** To reinstate a certification that has been lapsed for more than one year, documentation of continued competency in the procedures for which the surgeon is certified is required.

Continuing education hours and evidence of active practice in another state or in federal service, recent passage of a clinical competency examination, a refresher program offered by a program accredited by the Commission on Dental Accreditation of the American Dental Association or current certification by a professional credentialing board are considered in determining continuing competence. The optional employment verification form on page 4 may be used to document active practice. Completion of only home study, journal or internet courses is generally not sufficient to demonstrate continuing competence.

____ 5. **ABOMS Documentation:** Documentation verifying current board certification by the American Board of Oral and Maxillofacial Surgery (ABOMS) **or** documentation verifying board eligibility as defined by ABOMS.

____ 6. **Current Hospital Privileges:** Documentation confirming current privileges on a hospital staff to perform oral and maxillofacial surgery.

____ 7. 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 www.dhp.virginia.gov/dentistry.

____ 8. **Name Change:** Documentation must be provided to show each name change(s) if your name has ever been changed from the most recent time you held an active license in Virginia or were licensed in other jurisdictions or other than what is on record with the Virginia Board of Dentistry. Photocopies of marriage licenses or court orders are accepted. (May be mailed, faxed or emailed to the Board.)

____ 9. **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:

- Completed applications cannot be accessed or edited once they have been submitted. Failure to comply with legal requirements, failure to properly complete the application or failure to provide required documentation will result in the delay or denial of your application. Please check carefully to assure that all required information is provided with your application. It is your responsibility to maintain a copy of this application and all documents submitted to the Board or received from the Board for your future reference.

- To receive notice that your supporting documents have been delivered to the board, it is suggested that the documents be mailed by Fed-Ex or UPS with "Delivery Confirmation".

- Applicants will be notified 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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REINSTATEMENT APPLICATION FOR CERTIFICATION TO PERFORM COSMETIC PROCEDURES

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.

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	____ ____ ____---____ ____--____ ____ ____ ____

Virginia Dental License Number:	Virginia Oral & Maxillofacial Surgical Practice Registration Number

Name of Practice (if applicable):	Virginia Cosmetic Procedure Certification Number:	Date Certification Expired:

Check only one and attach a copy of documentation of American Board of Oral and Maxillofacial Surgery:

_____ Certification **OR** _____ Eligibility

Name of hospital where you currently hold privileges to perform oral and maxillofacial surgery: (Provide a copy of the letter confirming the privileges granted)

Have you practiced cosmetic dentistry (excluding the procedures noted in 18VAC60-20-300) since the expiration of your certification? Is yes, give location:

Reinstatement of Certification is sought for (check all that apply):

[ ] Rhinoplasty & other treatment of the nose;
[ ] Blepharoplasty & other treatment of the eyelid;
[ ] Rhytidectomy & other treatment of facial skin wrinkles & sagging;
[ ] Submental liposuction & other procedures to remove fat;
[ ] Browlift (either open or endoscopic technique) & other procedures to remove furrows & sagging skin on the upper eyelid & forehead;
[ ] Otoplasty & other procedures to change the appearance of the ear;
[ ] Laser resurfacing or dermabrasion & other procedures to remove facial skin irregularities;
[ ] Platysmal muscle plication & other procedures to correct the angle between the chin & neck;
[ ] Application of injectable medication or material for the purpose of treating extra-oral cosmetic conditions;

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

_____ _____
Signature of Applicant Date

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

***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	Date Expired	License #	Reinstatement Date

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EMPLOYMENT VERIFICATION

(Optional Form)

(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