

## INSTRUCTIONS FOR REACTIVATION OF DENTAL ASSISTANT II REGISTRATION

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. **Application:** Please be sure that all information and questions are completed on the application.
- \_\_\_\_\_ 2. **Application Fee:** The fee to reactivate a **Dental Assistant II Registration is \$50** 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 18VAC60-30-30(F), all fees are non-refundable. Your application will not be reviewed until you have submitted your payment.
- \_\_\_\_\_ 3. Evidence of a current credential as a **Certified Dental Assistant (CDA)** conferred by the Dental Assisting National Board (DANB) or another certification from a credentialing organization recognized by the American Dental Association and acceptable to the board.
- \_\_\_\_\_ 4. **Evidence of Continuing Clinical Competence:** The applicant must include documentation in the application sufficient to demonstrate continuing clinical competence in the duties for which the applicant is requesting reactivation of, which may include documentation of active practice in another state or in federal service, or a refresher course offered by an educational program accredited by the Commission on Dental Accreditation of the American Dental Association. The optional employment verification form on page 6 may be used to document active practice.
- \_\_\_\_\_ 5. **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 or registration in Virginia or in other jurisdictions or other than what is listed on your application. Photocopies of marriage licenses or court orders are accepted.
- \_\_\_\_\_ 6. 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 and 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](http://www.dhp.virginia.gov/dentistry).
- \_\_\_\_\_ 7. **Address of Record and Publicly 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 publicly disclosable address. If you do not want your Address of Record to be made public, state law allows you to provide a second, publicly 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 Registration is not reactivated within six months of the Board's receipt of parts of the application, certain portions of the application may need to be resubmitted before your application can be reviewed.
- To receive notice that your application has been delivered to the Board, it is suggested that the documents be mailed by "Certified Mail-Return Receipt Requested" or 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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**APPLICATION FOR REACTIVATION OF DENTAL ASSISTANT II REGISTRATION Page 1**

**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
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Address of Record (Mailing Address)	City	State	Zip Code	Telephone Number
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Public Disclosable Address	City	State	Zip Code	Telephone Number
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E-Mail Address	Fax #
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Date of Birth ____/____/____ Month Day Year	Social Security Number or <u>Virginia</u> DMV Control Number on record** ____-____-____
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Virginia DAll Registration Number	Date Inactive Status Taken:	Date of Last Active Practice
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Name at Time of Original Licensure (Last, First, Maiden)

Reactivation of Registration is sought for (check all that apply):

1. Performing pulp capping procedures  
 2. Packing and carving of amalgam restorations;  
 3. Placing and shaping composite resin restorations with a slow speed hand piece;  
 4. Taking final impressions;  
 5. Use of a non-epinephrine retraction cord;  
 6. Final cementation of crowns and bridges after adjustment and fitting by the dentist.

**\*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	Approved	Date License Reactivated	License Number
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**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

**Additional registration questions:**

1. A. Within the past five years, have you exhibited any conduct or behavior that could call into question your ability to practice in a competent and professional manner? If "YES", please provide a full explanation. [ ] Yes [ ] No

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B. Within the past five years, have you sought or been directed to seek treatment for your conduct or behavior? If "YES", please provide a full explanation. [ ] Yes [ ] No

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2. A. Within the past five years, have you been disciplined by any entity? If "YES", please provide a full explanation and any associated orders or letters from the entity. [ ] Yes [ ] No

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B. Within the past five years, have you sought or been directed to seek treatment for your conduct or behavior? If "YES", Please provide a full explanation and any associated orders or letters. [ ] Yes [ ] No

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3. Do you currently have any physical condition or impairment that affects or limits your ability to perform any of the obligations and responsibilities of professional practice in a safe and competent manner? [ ] Yes [ ] No

"Currently" means recently enough so that the condition could reasonably have an impact on your ability to function as a practicing dental assistant II. If "YES", please provide a full explanation. **NOTE:** The Board may request a letter from your current treatment provider addressing your current condition and ability to safely practice. You may consider providing this documentation with your application, or have your provider send this documentation directly to the Board.

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4. Do you currently have any mental health condition or impairment that affects or limits your ability to perform any of the obligations and responsibilities of professional practice in a safe and competent manner? [ ] Yes [ ] No

"Currently" means recently enough so that the condition could reasonably have an impact on your ability to function as a practicing dental assistant II. If "YES", please provide a full explanation. **NOTE:** The Board may request a letter from your current treatment provider addressing your current condition and ability to safely practice. You may consider providing this documentation with your application, or have your provider send this documentation directly to the Board.

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5. Do you currently have any condition or impairment related to alcohol or other substance use that affects or limits your ability to perform any of the obligations and responsibilities of professional practice in a safe and competent manner?  Yes  No

“Currently” means recently enough so that the condition could reasonably have an impact on your ability to function as a practicing dental assistant II. If “YES”, please provide a full explanation. **NOTE:** The Board may request a letter from your current treatment provider addressing your current condition and ability to safely practice. You may consider providing this documentation with your application, or have your provider send this documentation directly to the Board.

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6. Within the past 5 years, have any conditions or restrictions been imposed upon you or your practice to avoid disciplinary action by any entity?  Yes  No

If “YES”, please provide a full explanation and any associated orders or letters from the entity. **NOTE:** The Board may request a copy of a current participation contract and summary of compliance and/or documentation of successful completion. You may consider providing this documentation with your application, or have the program send this documentation directly to the Board.

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**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 assistants. I hereby agree to abide by and remain current with the applicable laws and regulations which are available on [www.dhp.virginia.gov/dentistry](http://www.dhp.virginia.gov/dentistry), 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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(804) 367-4538 (Tel)  
(804) 698-4266 (eFax)  
[denbd@dhp.virginia.gov](mailto:denbd@dhp.virginia.gov)  
[www.dhp.virginia.gov/dentistry](http://www.dhp.virginia.gov/dentistry)

### 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 practice of a \_\_\_\_\_  
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

**SEAL/STAMP**

\_\_\_\_\_  
Signature of Notary Public

\_\_\_\_\_  
Print Name