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 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's 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. 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 or may send your application to Enforcement for an investigation.

__ 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. **Official Transcript or Certification of completed OMS program:** 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. **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. **Certification of Completion of Training:** For each procedure you are applying for certification to perform, check the requirement that applies to you and attach the appropriate documentation.

- If you oral and maxillofacial residency or cosmetic clinical fellowship was completed after July 1, 1996, and training in cosmetic surgery was a part of such residency or fellowship, submit:
  a. A letter from the director of the residency or fellowship program documenting the training received in the residency or in the clinical fellowship to substantiate adequate training in the specific procedures for which the applicant is seeking certification; and
  b. Documentation of having performed as primary or assistant surgeon at least 10 proctored cases in each of the procedures for which he seeks to be certified.

- If your oral and maxillofacial residency was completed prior to July 1, 1996, or if his oral and maxillofacial residency was completed after July 1, 1996, and training in cosmetic surgery was not a part of the applicant's residency, submit:
  a. Documentation of having completed didactic and clinically approved courses to include the dates attended, the location of the course, and a copy of the certificate of attendance. Courses shall provide sufficient training in the specific procedures requested for certification and shall be offered by:
     1. An advanced specialty education program in oral and maxillofacial surgery accredited by the Commission on Dental Accreditation;
     2. A medical school accredited by the Liaison Committee on Medical Education or other official accrediting body recognized by the American Medical Association;
     3. The American Dental Association or one of its constituent and component societies or other ADA Continuing Education Recognized Programs (CERP) approved for continuing dental education; or
     4. The American Medical Association approved for category 1, continuing medical education; and
  b. Documentation of either:
     1. Holding current privileges to perform cosmetic surgical procedures within a hospital accredited by the Joint Commission on Accreditation of Healthcare Organizations; or
     2. Having completed at least 10 cases as primary or secondary surgeon in the specific procedures for which the applicant is seeking certification, of which at least five shall be proctored cases as defined in this chapter.

__ 8. **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 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.

__ 9. 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/

__ 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.

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 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 CERTIFICATION TO PERFORM COSMETIC PROCEDURES 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

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):

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)

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;

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	APPLICANT #	LICENSE #	DATE ISSUED

II. Additional licensure questions (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. 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

_____

_____

4. 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

_____

_____

5. 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

_____

_____

6. 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

_____

_____

By signing below, I 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 further certify that I have carefully read the laws and regulations applicable to the certification to perform cosmetic procedures and hereby agree to abide by and remain current with the applicable laws and regulations which are available online at www.dhp.virginia.gov/dentistry.

_____ _____

Signature of applicant Date

Name (Last, First, M.I., Suffix, Maiden Name)	**Virginia Dental License Number**

RHINOPLASTY AND OTHER TREATMENT OF THE NOSE:

Check the requirement that applies to you and attach the appropriate documentation:

_____ My residency program completion date is after July 1, 1996, and training in cosmetic procedures was part of the residency. I am attaching a letter from the program director documenting the training provided in rhinoplasty and other treatment of the nose and documentation from the program verifying that I performed as primary or assistant surgeon, at least 10 proctored cases in rhinoplasty and other treatment of the nose.

OR

_____ My residency program completion date is prior to July 1, 1996, **or** my residency program was completed after July 1, 1996, and did not include training in cosmetic procedures. I am attaching all of the following:

1) Documentation of having completed didactic and clinically approved courses specific to rhinoplasty and other treatment of the nose that includes the course title, dates attended, and the location of the course and, the certificate for each course listed. These documents confirm that the courses were obtained from an advanced specialty education program in oral and maxillofacial surgery accredited by the Commission on Dental Accreditation, a medical school accredited by the Liaison Committee on Medical Education or other official accrediting body recognized by the American Medical Association, the American Dental Association (ADA) or one of its constituent and component societies or other ADA Continuing Education Recognized Programs (CERP) approved for continuing dental education, or the American Medical Association, approved for category 1, continuing medical education.

AND

2) Documentation of current privileges to perform cosmetic surgical procedures within a hospital accredited by the Joint Commission on Accreditation of Healthcare Organizations, **or;**

   Documentation of having completed at least 10 cases as primary or secondary surgeon in rhinoplasty and other treatment of the nose of which at least 5 were proctored.

Name (Last, First, M.I., Suffix, Maiden Name)	**Virginia Dental License Number**

BLEPHAROPLASTY AND OTHER TREATMENT OF THE EYELID:

Check the requirement that applies to you and attach the appropriate documentation:

_____ My residency program completion date is after July 1, 1996, and training in cosmetic procedures was part of the residency. I am attaching a letter from the program director documenting the training provided in blepharoplasty and other treatment of the eyelid and documentation from the program verifying that I performed as primary or assistant surgeon, at least 10 proctored cases in blepharoplasty and other treatment of the eyelid.

OR

_____ My residency program completion date is prior to July 1, 1996, **or** my residency program was completed after July 1, 1996, and did not include training in cosmetic procedures. I am attaching all of the following:

1) Documentation of having completed didactic and clinically approved courses specific to blepharoplasty and other treatment of the eyelid that includes the course title, dates attended, and the location of the course and, the certificate for each course listed. These documents confirm that the courses were obtained from an advanced specialty education program in oral and maxillofacial surgery accredited by the Commission on Dental Accreditation, a medical school accredited by the Liaison Committee on Medical Education or other official accrediting body recognized by the American Medical Association, the American Dental Association (ADA) or one of its constituent and component societies or other ADA Continuing Education Recognized Programs (CERP) approved for continuing dental education, or the American Medical Association, approved for category 1, continuing medical education.

AND

2) Documentation of current privileges to perform cosmetic surgical procedures within a hospital accredited by the Joint Commission on Accreditation of Healthcare Organizations, **or;**

   Documentation of having completed at least 10 cases as primary or secondary surgeon in blepharoplasty and other treatment of the eyelid of which at least 5 were proctored.

Name (Last, First, M.I., Suffix, Maiden Name)	**Virginia Dental License Number**

RHYTIDECTOMY AND OTHER TREATMENT OF FACIAL SKIN WRINKLES AND SAGGING:

Check the requirement that applies to you and attach the appropriate documentation:

_____ My residency program completion date is after July 1, 1996, and training in cosmetic procedures was part of the residency. I am attaching a letter from the program director documenting the training provided in rhytidectomy and other treatment of facial skin wrinkles and sagging and documentation from the program verifying that I performed as primary or assistant surgeon, at least 10 proctored cases in rhytidectomy and other treatment of facial skin wrinkles and sagging.

OR

_____ My residency program completion date is prior to July 1, 1996, **or** my residency program was completed after July 1, 1996, and did not include training in cosmetic procedures. I am attaching all of the following:

1) Documentation of having completed didactic and clinically approved courses specific to rhytidectomy and other treatment of facial skin wrinkles and sagging that includes the course title, dates attended, and the location of the course and, the certificate for each course listed. These documents confirm that the courses were obtained from an advanced specialty education program in oral and maxillofacial surgery accredited by the Commission on Dental Accreditation, a medical school accredited by the Liaison Committee on Medical Education or other official accrediting body recognized by the American Medical Association, the American Dental Association (ADA) or one of its constituent and component societies or other ADA Continuing Education Recognized Programs (CERP) approved for continuing dental education, or the American Medical Association, approved for category 1, continuing medical education.

AND

2) Documentation of current privileges to perform cosmetic surgical procedures within a hospital accredited by the Joint Commission on Accreditation of Healthcare Organizations, **or;**

   Documentation of having completed at least 10 cases as primary or secondary surgeon in rhytidectomy and other treatment of facial skin wrinkles and sagging of which at least 5 were proctored.

Name (Last, First, M.I., Suffix, Maiden Name)	**Virginia Dental License Number**

SUBMENTAL LIPOSUCTION AND OTHER PROCEDURES TO REMOVE FAT:

Check the requirement that applies to you and attach the appropriate documentation:

_____ My residency program completion date is after July 1, 1996, and training in cosmetic procedures was part of the residency. I am attaching a letter from the program director documenting the training provided in submental liposuction and other procedures to remove fat and documentation from the program verifying that I performed as primary or assistant surgeon, at least 10 proctored cases in submental liposuction and other procedures to remove fat.

OR

_____ My residency program completion date is prior to July 1, 1996, **or** my residency program was completed after July 1, 1996, and did not include training in cosmetic procedures. I am attaching all of the following:

1) Documentation of having completed didactic and clinically approved courses specific to submental liposuction and other procedures to remove fat that includes the course title, dates attended, and the location of the course and, the certificate for each course listed. These documents confirm that the courses were obtained from an advanced specialty education program in oral and maxillofacial surgery accredited by the Commission on Dental Accreditation, a medical school accredited by the Liaison Committee on Medical Education or other official accrediting body recognized by the American Medical Association, the American Dental Association (ADA) or one of its constituent and component societies or other ADA Continuing Education Recognized Programs (CERP) approved for continuing dental education, or the American Medical Association, approved for category 1, continuing medical education.

AND

2) Documentation of current privileges to perform cosmetic surgical procedures within a hospital accredited by the Joint Commission on Accreditation of Healthcare Organizations, **or;**

   Documentation of having completed at least 10 cases as primary or secondary surgeon in submental liposuction and other procedures to remove fat of which at least 5 were proctored.

Name (Last, First, M.I., Suffix, Maiden Name)	Virginia Dental License Number

BROWLIFT (EITHER OPEN OR ENDOSCOPIC TECHNIQUE) AND OTHER PROCEDURES TO REMOVE FURROWS AND SAGGING SKIN ON THE UPPER EYELID OR FOREHEAD:

Check the requirement that applies to you and attach the appropriate documentation:

_____ My residency program completion date is after July 1, 1996, and training in cosmetic procedures was part of the residency. I am attaching a letter from the program director documenting the training provided in browlift (either open or endoscopic technique) and other procedures to remove furrows and sagging skin on the upper eyelid or forehead and documentation from the program verifying that I performed as primary or assistant surgeon, at least 10 proctored cases in in browlift (either open or endoscopic technique) and other procedures to remove furrows and sagging skin on the upper eyelid or forehead.

OR

_____ My residency program completion date is prior to July 1, 1996, **or** my residency program was completed after July 1, 1996, and did not include training in cosmetic procedures. I am attaching all of the following:

1) Documentation of having completed didactic and clinically approved courses specific to browlift (either open or endoscopic technique) and other procedures to remove furrows and sagging skin on the upper eyelid or forehead that includes the course title, dates attended, and the location of the course and, the certificate for each course listed. These documents confirm that the courses were obtained from an advanced specialty education program in oral and maxillofacial surgery accredited by the Commission on Dental Accreditation, a medical school accredited by the Liaison Committee on Medical Education or other official accrediting body recognized by the American Medical Association, the American Dental Association (ADA) or one of its constituent and component societies or other ADA Continuing Education Recognized Programs (CERP) approved for continuing dental education, or the American Medical Association, approved for category 1, continuing medical education.

AND

2) Documentation of current privileges to perform cosmetic surgical procedures within a hospital accredited by the Joint Commission on Accreditation of Healthcare Organizations, **or;**

   Documentation of having completed at least 10 cases as primary or secondary surgeon in browlift (either open or endoscopic technique) and other procedures to remove furrows and sagging skin on the upper eyelid or forehead of which at least 5 were proctored.

Name (Last, First, M.I., Suffix, Maiden Name)	**Virginia Dental License Number**

OTOPLASTY AND OTHER PROCEDURES TO CHANGE THE APPEARANCE OF THE EAR:

Check the requirement that applies to you and attach the appropriate documentation:

_____ My residency program completion date is after July 1, 1996, and training in cosmetic procedures was part of the residency. I am attaching a letter from the program director documenting the training provided in Otoplasty and other procedures to change the appearance of the ear and documentation from the program verifying that I performed as primary or assistant surgeon, at least 10 proctored cases in Otoplasty and other procedures to change the appearance of the ear.

OR

_____ My residency program completion date is prior to July 1, 1996, **or** my residency program was completed after July 1, 1996, and did not include training in cosmetic procedures. I am attaching all of the following:

1) Documentation of having completed didactic and clinically approved courses specific to Otoplasty and other procedures to change the appearance of the ear that includes the course title, dates attended, and the location of the course and, the certificate for each course listed. These documents confirm that the courses were obtained from an advanced specialty education program in oral and maxillofacial surgery accredited by the Commission on Dental Accreditation, a medical school accredited by the Liaison Committee on Medical Education or other official accrediting body recognized by the American Medical Association, the American Dental Association (ADA) or one of its constituent and component societies or other ADA Continuing Education Recognized Programs (CERP) approved for continuing dental education, or the American Medical Association, approved for category 1, continuing medical education.

AND

2) Documentation of current privileges to perform cosmetic surgical procedures within a hospital accredited by the Joint Commission on Accreditation of Healthcare Organizations, **or;**

   Documentation of having completed at least 10 cases as primary or secondary surgeon in Otoplasty and other procedures to change the appearance of the ear, of which at least 5 were proctored.

Name (Last, First, M.I., Suffix, Maiden Name)	**Virginia Dental License Number**

LASER RESURFACING OR DERMABRASION AND OTHER PROCEDURES TO REMOVE FACIAL SKIN IRREGULARITIES:

Check the requirement that applies to you and attach the appropriate documentation:

_____ My residency program completion date is after July 1, 1996, and training in cosmetic procedures was part of the residency. I am attaching a letter from the program director documenting the training provided in laser resurfacing or dermabrasion and other procedures to remove facial skin irregularities and documentation from the program verifying that I performed as primary or assistant surgeon, at least 10 proctored cases in laser resurfacing or dermabrasion and other procedures to remove facial skin irregularities.

OR

_____ My residency program completion date is prior to July 1, 1996, **or** my residency program was completed after July 1, 1996, and did not include training in cosmetic procedures. I am attaching all of the following:

1) Documentation of having completed didactic and clinically approved courses specific to laser resurfacing or dermabrasion and other procedures to remove facial skin irregularities that includes the course title, dates attended, and the location of the course and, the certificate for each course listed. These documents confirm that the courses were obtained from an advanced specialty education program in oral and maxillofacial surgery accredited by the Commission on Dental Accreditation, a medical school accredited by the Liaison Committee on Medical Education or other official accrediting body recognized by the American Medical Association, the American Dental Association (ADA) or one of its constituent and component societies or other ADA Continuing Education Recognized Programs (CERP) approved for continuing dental education, or the American Medical Association, approved for category 1, continuing medical education.

AND

2) Documentation of current privileges to perform cosmetic surgical procedures within a hospital accredited by the Joint Commission on Accreditation of Healthcare Organizations, **or;**

   Documentation of having completed at least 10 cases as primary or secondary surgeon in laser resurfacing or dermabrasion and other procedures to remove facial skin irregularities, of which at least 5 were proctored.

Name (Last, First, M.I., Suffix, Maiden Name)	**Virginia Dental License Number**

PLATYSMAL MUSCLE PLICATION AND OTHER PROCEDURES TO CORRECT THE ANGLE BETWEEN THE CHIN AND NECK:

Check the requirement that applies to you and attach the appropriate documentation:

_____ My residency program completion date is after July 1, 1996, and training in cosmetic procedures was part of the residency. I am attaching a letter from the program director documenting the training provided in Platysmal muscle plication and other procedures to correct the angle between the chin and neck, and documentation from the program verifying that I performed as primary or assistant surgeon, at least 10 proctored cases in Platysmal muscle plication and other procedures to correct the angle between the chin and neck.

OR

_____ My residency program completion date is prior to July 1, 1996, **or** my residency program was completed after July 1, 1996, and did not include training in cosmetic procedures. I am attaching all of the following:

1) Documentation of having completed didactic and clinically approved courses specific to Platysmal muscle plication and other procedures to correct the angle between the chin and neck that includes the course title, dates attended, and the location of the course and, the certificate for each course listed. These documents confirm that the courses were obtained from an advanced specialty education program in oral and maxillofacial surgery accredited by the Commission on Dental Accreditation, a medical school accredited by the Liaison Committee on Medical Education or other official accrediting body recognized by the American Medical Association, the American Dental Association (ADA) or one of its constituent and component societies or other ADA Continuing Education Recognized Programs (CERP) approved for continuing dental education, or the American Medical Association, approved for category 1, continuing medical education.

AND

2) Documentation of current privileges to perform cosmetic surgical procedures within a hospital accredited by the Joint Commission on Accreditation of Healthcare Organizations, **or;**

   Documentation of having completed at least 10 cases as primary or secondary surgeon in Platysmal muscle plication and other procedures to correct the angle between the chin and neck, of which at least 5 were proctored.

Name (Last, First, M.I., Suffix, Maiden Name)	**Virginia Dental License Number**

APPLICATION OF INJECTABLE MEDICATION OR MATERIAL FOR THE PURPOSE OF TREATING EXTRA-ORAL COSMETIC CONDITIONS:

Check the requirement that applies to you and attach the appropriate documentation:

_____ My residency program completion date is after July 1, 1996, and training in cosmetic procedures was part of the residency. I am attaching a letter from the program director documenting the training provided in application of injectable medication or material for the purpose of treating extra-oral cosmetic conditions, and documentation from the program verifying that I performed as primary or assistant surgeon, at least 10 proctored cases in application of injectable medication or material for the purpose of treating extra-oral cosmetic conditions.

OR

_____ My residency program completion date is prior to July 1, 1996, **or** my residency program was completed after July 1, 1996, and did not include training in cosmetic procedures. I am attaching all of the following:

1) Documentation of having completed didactic and clinically approved courses specific to application of injectable medication or material for the purpose of treating extra-oral cosmetic conditions that includes the course title, dates attended, and the location of the course and, the certificate for each course listed. These documents confirm that the courses were obtained from an advanced specialty education program in oral and maxillofacial surgery accredited by the Commission on Dental Accreditation, a medical school accredited by the Liaison Committee on Medical Education or other official accrediting body recognized by the American Medical Association, the American Dental Association (ADA) or one of its constituent and component societies or other ADA Continuing Education Recognized Programs (CERP) approved for continuing dental education, or the American Medical Association, approved for category 1, continuing medical education.

AND

2) Documentation of current privileges to perform cosmetic surgical procedures within a hospital accredited by the Joint Commission on Accreditation of Healthcare Organizations, **or;**

   Documentation of having completed at least 10 cases as primary or secondary surgeon in application of injectable medication or material for the purpose of treating extra-oral cosmetic conditions, of which at least 5 were proctored.

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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 professional dental credential/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
[ ] Certification To Perform Cosmetic Procedures
[ ] 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
[ ] Oral & Maxillofacial Surgeon Registration

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