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
www.dhp.virginia.gov/dentistry

INSTRUCTIONS FOR REINSTATMENT 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 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 or may send your application to Enforcement for an investigation.

___ 2. **Application Fee:** **Lapsed** Dental Assistant II Registration reinstatement fee is **$125.00**
Previously **Revoked** Dental Assistant II Registration reinstatement fee is **$300.00**
Previously **Suspended** Dental Assistant II Registration reinstatement fee is **$250.00**

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 18VAC60-30-30(F), all fees are non-refundable. Your application will not be reviewed until you have submitted payment.

___ 3. **Evidence of a current credential as a Certified Dental Assistant (CDA):** A CDA conferred by the Dental Assisting National Board (DANB) or another certification from a credentialing organization recognized by the American Dental Association (ADA) and acceptable to the board, which was granted following passage of an examination on general chairside assisting, radiation health and safety, and infection control.

___ 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 reinstatement 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 employment verification form on page 6 may be used to document active practice. **Note:** It is the applicant's responsibility to prove clinical competency (see guidance document 60-12).

___ 5. **Form C License/Registration Verification:** **Original** licensure/registration status and certification from every jurisdiction in which you currently hold or have ever held a license/registration/certification to practice as a dental assistant II 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 dental assistant II 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.

___ 6. **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.

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

___ 8. **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 registration is not reinstated within six months within six months of the of the date of your other certification of state licensure/registration, then you will be asked to submit a current state certification before your application can be reviewed for approval.

- 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 <u>not</u> the Board**.

- Applicant will be notified by email 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.

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APPLICATION FOR REINSTATEMENT OF DENTAL ASSISTANT II REGISTRATION

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**
____ ____ ____--____ ____ --____ ____ ____ ____

Virginia DAII Registration Number: Date of Expiration: Name at time of Original Registration*

Reinstatement 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.

Please check the applicable box below:

☐ REINSTATEMENT REQUESTED DUE TO LAPSE OF REGISTRATION

☐ 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 dental assisting since the expiration of your registration in the Commonwealth of Virginia or in another jurisdiction? If "YES", give location._____ [ ] Yes [ ] No

4. Has any of your work since the expiration of your registration been in any field other than the field 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 in the field of dentistry or in any other health care profession:

Jurisdiction	License Number	Date Issued	Expiration Date
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

6. 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.

   _____

   _____

7. 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 Registration 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 assisting. 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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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 certify that _____
(Supervising Dentist) (Applicant)

was employed by me from _____/_____/_____ to _____/_____/_____ as a dental assistant who
Month Day Year Month Day Year

performed the following expanded didactic, laboratory and clinical duties:

Check each 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.

_____
Signature/Date

Notary:

State of _____

County/City of _____

Sworn and subscribed to, before, this _____day of (Month) _____, Year _____.

My Commission expires on _____.

_____
Signature of Notary Public

SEAL/STAMP

_____
Print Name

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FORM C

CERTIFICATION OF AUTHORIZATION TO PERFORM EXPANDED DUTIES AS A DENTAL ASSISTANT

Please forward one form to each state dental board where you hold or have ever held registration as a dental assistant. 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 registration in Virginia by:

[ ] Examination for Dental Assistant II [ ] Endorsement for Dental Assistant II

I, was granted License/Registration Number _____, on _____ by the
Month Date Year

State of _____. The Virginia Board of Dentistry requires that I submit evidence of the status of my license/registration. 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 Type & #_____ Issued_____

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

Please check all duties the licensee is currently authorized to perform:

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.

License is: [ ] Current-Expires on_____ [ ] 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