



INSTRUCTIONS FOR A TEMPORARY DENTAL PERMIT

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.

Note: Code of Virginia § 54.1-2715. Temporary permits for certain clinicians.

- A. The Board may issue a temporary permit to a graduate of a dental school or college or the dental department of a college or university, who
- (i) has a D.D.S. or D.M.D. degree and is otherwise qualified,
 - (ii) is not licensed to practice dentistry in Virginia, **and**
 - (iii) has not failed an examination for a license to practice dentistry in the Commonwealth.

Such temporary permits may be issued only to those eligible graduates who serve as clinicians in dental clinics operated by

- (a) the Virginia Department of Corrections,
- (b) the Virginia Department of Health,
- (c) the Virginia Department of Behavioral Health and Developmental Services, **or**
- (d) a Virginia charitable corporation granted tax-exempt status under § 501 (c) (3) of the Internal Revenue Code and operating as a clinic for the indigent and uninsured that is organized for the delivery of primary health care services:
 - (i) as a federal qualified health center designated by the Centers for Medicare and Medicaid Services **or**
 - (ii) at a reduced or sliding fee scale or without charge.

- B. Applicants for temporary permits shall be certified to the executive director of the Board by the:

- o Director of the Department of Corrections,
- o the Commissioner of Health,
- o the Commissioner of Behavioral Health and Developmental Services, **or**
- o the chief executive officer of a Virginia charitable corporation identified in subsection A.

The holder of such a temporary permit shall not be entitled to receive any fee or other compensation other than salary. Such permits shall be valid for no more than two years and shall expire on the June 30 of the second year after their issuance, or shall terminate when the holder ceases to serve as a clinician with the certifying agency or charitable corporation. Such permits may be reissued annually or may be revoked at any time for cause. Reissuance or revocation of a temporary permit is in the discretion of the Board.

- C. Dentists licensed pursuant to this chapter may practice as employees of the dental clinics operated as specified in subsection A.

- 1. **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.**
- 2. **Application Fee:** The fee for a **temporary dental permit is \$400** 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.
- 3. **Official Transcript:** 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.**

4. **Form A Certification of Graduation (For Post-Doctoral Specialty Programs Only):** Original certification of graduation by each post-doctoral specialty dental school which granted you a dental degree or certificate from a dental program accredited by the Commission on Dental Accreditation of the American Dental Association (CODA) or the Commission on Dental Accreditation of Canada (CDAC), at least a 12-month post-doctoral advanced general dentistry program or a post-doctoral dental education program of at least 24 months that includes a **clinical component**.

Applicants must submit a Form A for **each** degree and/or certificate earned from a post-doctoral specialty dental program accredited by CODA or CDAC. The school may use this form or its own form to meet this requirement.

The certification form must bear the school's seal or be on letterhead bearing the school's seal and must include the program's CODA/CDAC accreditation status at the time you completed the program. This information is only accepted from programs accredited by CODA or CDAC.

(Options: Mail to the Board (address listed above), or the school/agency **official** representative may email the documentation to bodlicensing@dhp.virginia.gov. Faxed copies are not acceptable.)

Documentation from foreign countries non-accredited CODA/CDAC schools' programs is not required and will not be considered.

5. **Form B Chronology:** List **ALL** personal and professional activities, to include all time periods of employment and unemployment, since receiving your doctoral degree or post-doctoral advanced certification. (*Resumes and curriculum vitae are not accepted as substitutes for completing the chronological listing on Form B and will not be considered.*)

6. **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.

7. **Letter of Employment:** Original letter from the State Agency Director or Commissioner or the chief executive officer of the Virginia charitable corporation, on letterhead, certifying that you are being hired by the agency or corporation to serve as a clinician in the specified dental clinic.

Applicants for a Temporary Dental Permit who will serve as clinician in a dental clinic operated by a Virginia charitable corporation are **additionally required to:**

Provide documentation verifying the charitable corporation's tax exempt status under §501(c)(3) of the Internal Revenue Code, and that it operates as a clinic for the indigent and uninsured that is organized for the delivery of primary health care services:

- A. As a federal qualified health center designated by the Centers for Medicare and Medicaid Services, or;
- B. At a reduced or sliding fee scale or without charge

8. **NPDB:** An **original** 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).

9. **NBDE:** An **original** grade card **showing passage of all parts of the National Board Dental Examination** issued by the Joint Commission on National Dental Examinations is required. Copies of grade cards are not accepted. (You must contact the testing agency to request that your test results be made available to the Virginia Board of Dentistry via their online access portal and then notify the Board when it is available.)

- ___ 10. **Legal/Name Change:** Documentation must be provided to show each name change if your name has ever 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. Please be aware that your electronic signature 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/>.
- ___ 12. **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:

- **The holder of a Temporary Dental Permit shall not be entitled to receive any fee or compensation other than salary.**
- Such permits shall be valid for no more than two years and shall expire on June 30th of the second year after their issuance, or shall terminate when the holder ceases to serve as a clinician with the certifying agency or corporation. Such permit may be renewed if extraordinary circumstances prevented the holder from qualifying for an unrestricted license.
- If your Virginia permit is not issued 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.
- **DEA Registration:** Applicants must have a dental license prior to applying for a DEA License. Requests for an application in Virginia should be made to the following: Drug Enforcement Administration, Attn: Registration Section/ODR, P.O. Box 2639, Springfield, VA 22152-2639; 1-800-882-9539; www.deadiversion.usdoj.gov
- 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 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.

Related contact information:

National Practitioner Data Bank

P.O. Box 10832
Chantilly, VA 20153
1-800-767-6732

www.npdb.hrsa.gov

Joint Commission on National Dental Examinations (NBDE)

211 East Chicago Avenue
Chicago, IL 60611-2678
1-800-232-1694

<https://jcnde.ada.org/>



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/>

APPLICATION FOR A TEMPORARY DENTAL PERMIT 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
Publicly Disclosable Address	City	State	Zip Code Telephone Number
Email Address	Fax#		

Date of Birth ____/____/____ Month Day Year	Social Security Number or Virginia DMV control Number** ____-____-____
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DDS/DMD GRADUATION DATE ____/____/____ Month Day Year	PROFESSIONAL DEGREE (DDS/DMD)	CODA/CDAC APPROVED DENTAL SCHOOL/CITY/STATE
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RESIDENCY/SPECIALTY GRADUATION DATE ____/____/____ Month Day Year	RESIDENCY/SPECIALTY DEGREE or CERTIFICATE	CODA/CDAC APPROVED DENTAL SCHOOL/CITY/STATE
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APPLICANTS DO NOT USE SPACES BELOW THIS LINE – FOR OFFICE USE ONLY

DATE RECEIVED	CHRONOLOGY (FORM B)	NATIONAL PRACTITIONER DATA BANK	NATIONAL BOARD
TRANSCRIPT	CERTIFICATION (EDUCATION) (FORM A)	CERTIFICATION (LICENSE FROM OTHER STATES) (FORM C or Letter)	

***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	APPLICANT #	LICENSE #	DATE ISSUED	VERIFY NEVER LICENSED IN VIRGINIA
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APPLICATION FOR A TEMPORARY DENTAL PERMIT Application Page 2

II. ALL EXAMINATIONS: Answer all questions “1” through “8”

- | | |
|--|--|
| <p>1. Southern Regional Testing Agency (SRTA) –Exam Site _____</p> <p>[] Passed [] Failed [] Never Taken [] Taken more than once (attach explanation)</p> | <p>_____/_____/_____
Month/ Day / Year</p> |
| <p>2. Western Regional Examining Board (WREB) –Exam Site _____</p> <p>[] Passed [] Failed [] Never Taken [] Taken more than once (attach explanation)</p> | <p>_____/_____/_____
Month/ Day / Year</p> |
| <p>3. North East Regional Board (NERB/CDCA) –Exam Site _____</p> <p>[] Passed [] Failed [] Never Taken [] Taken more than once (attach explanation)</p> | <p>_____/_____/_____
Month/ Day / Year</p> |
| <p>4. Central Regional Dental Testing Services, Inc. (CRDTS) –Exam Site _____</p> <p>[] Passed [] Failed [] Never Taken [] Taken more than once (attach explanation)</p> | <p>_____/_____/_____
Month/ Day / Year</p> |
| <p>5. Council of Interstate Testing Agencies, Inc. (CITA) –Exam Site _____</p> <p>[] Passed [] Failed [] Never Taken [] Taken more than once (attach explanation)</p> | <p>_____/_____/_____
Month/ Day / Year</p> |
| <p>6. CDCA-WREB-CITA (ADEX) –Exam Site _____</p> <p>[] Passed [] Failed [] Never Taken [] Taken more than once (attach explanation)</p> | <p>_____/_____/_____
Month/ Day / Year</p> |
| <p>7. State of _____ –Exam Site _____</p> <p>[] Passed [] Failed [] Never Taken [] Taken more than once (attach explanation)</p> | <p>_____/_____/_____
Month/ Day / Year</p> |
| <p>8. National Board Examination: (Original grade cards are required)</p> <p>[] Passed [] Failed [] Never Taken [] Taken more than once (attach explanation)</p> | <p>_____/_____/_____
Month/ Day / Year</p> |

The Board must receive an original score card or report from the testing agency for each examination reported above. See the Application Instructions #9 for more details of the above #8.

III. 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.

- | | | | | | | | | | | | | |
|---|----------------------------------|----------------------------------|---------------|----------------|-------|-------|----------------|-------|-------|----------------|-------|-------|
| <p>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, <u>or</u> 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</p> <p>2. Are you active-duty military? If “YES”, include a copy of your official military orders with the application. [] Yes [] No</p> <p>3. List in chronological order including months and years, the dental school(s) attended (include specialty and advanced programs):</p> <table border="0" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 30%; text-align: left;">Months & Years</td> <td style="width: 40%; text-align: left;">Name of Dental School (ADA-CODA)</td> <td style="width: 30%; text-align: left;">Passed/Failed</td> </tr> <tr> <td>_____ to _____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>_____ to _____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>_____ to _____</td> <td>_____</td> <td>_____</td> </tr> </table> | Months & Years | Name of Dental School (ADA-CODA) | Passed/Failed | _____ to _____ | _____ | _____ | _____ to _____ | _____ | _____ | _____ to _____ | _____ | _____ |
| Months & Years | Name of Dental School (ADA-CODA) | Passed/Failed | | | | | | | | | | |
| _____ to _____ | _____ | _____ | | | | | | | | | | |
| _____ to _____ | _____ | _____ | | | | | | | | | | |
| _____ to _____ | _____ | _____ | | | | | | | | | | |

APPLICATION FOR A TEMPORARY DENTAL PERMIT Application Page 3

4.	List all jurisdictions in which you currently hold or have ever held a license/registration/certification to practice as a dentist or as another health care professional.																					
	<table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 20%;">Jurisdiction</th> <th style="width: 20%;">Number</th> <th style="width: 20%;">Type</th> <th style="width: 20%;">Date Issued</th> <th style="width: 20%;">Exp. Date</th> </tr> </thead> <tbody> <tr> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> </tr> </tbody> </table>	Jurisdiction	Number	Type	Date Issued	Exp. Date	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	
Jurisdiction	Number	Type	Date Issued	Exp. Date																		
_____	_____	_____	_____	_____																		
_____	_____	_____	_____	_____																		
_____	_____	_____	_____	_____																		
5.	Have you ever been dropped, suspended, expelled, or disciplined by any school or college for any cause whatever? If "YES", give details, schools(s), address(es) and date(s). Please note: the Board may ask for additional documentation.	[] Yes [] No																				

6.	Have you ever been denied a license, or the privilege of taking a dental licensure/competency examination by a licensing authority? 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																				

8.	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.) <b style="color: red;">"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.																					

9.	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																				

10.	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																				

11.	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																				

12.	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.																					

APPLICATION FOR A TEMPORARY DENTAL PERMIT Application Page 4

13. 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 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



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/>

FORM A
CERTIFICATION OF DENTAL SCHOOL
Post-Doctoral Specialty Programs ONLY

Applicant: Enter **only** your name and graduation date below, then send this form to the Dean or Director of each Dental School or Program which granted you a degree or certificate.

APPLICANT _____ **GRADUATION DATE:** _____

DEAN/PROGRAM DIRECTOR: Please provide certification that the applicant named above received a dental degree or certificate from your program and certification that the program completed was accredited by the Commission on Dental Accreditation of the ADA (CODA) or the Commission on Dental Accreditation of Canada (CDAC) at the time the applicant completed the program. The certification may be provided by completing this form or by providing a letter with all the information requested on this form. Either document must bear the school's seal.

Certifications made prior to the applicant's graduation cannot be accepted.

NAME OF SCHOOL: _____

NAME OF PROGRAM: _____

PROGRAM'S CODA/CDAC ACCREDITATION STATUS ON THE DATE THE DEGREE OR CERTIFICATION WAS GRANTED:

- A1: Approval (without reporting requirements) []
- A2: Approval (with reporting requirements) []
- IA: Initial accreditation []
- DIS: Accreditation voluntarily discontinued []
- WDRN: Accreditation withdrawn []
- X: Intent to withdraw accreditation []
- T: Program is in Teach-Out by institution []
- NE: Required period of non-enrollment []

DEGREE or CERTIFICATION GRANTED: _____

DATE GRANTED: _____ / _____ / _____
Month Day Year

By affixing my signature below, I certify that the applicant named above is a graduate and a holder of a diploma or a certificate from a CODA/CDAC accredited dental program.

SEAL

Signature

Print Name

Title

Date

DEAN/REGISTRAR: Please provide the applicant an original final transcript of this alumni record, to include courses, grades, degree or certificate received, and date the degree or certificate was conferred, which bears the certified signature of the registrar and has the college seal affixed.



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/>

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:

- | | | |
|---|---|--|
| <input type="checkbox"/> Examination for Dental License | <input type="checkbox"/> Examination for Dental Hygiene License | <input type="checkbox"/> Dental Restricted Volunteer License |
| <input type="checkbox"/> Credentials for Dental License | <input type="checkbox"/> Credentials for Dental Hygiene License | <input type="checkbox"/> Dental Hygiene Restricted Volunteer License |
| <input type="checkbox"/> Dental Faculty License | <input type="checkbox"/> Dental Hygiene Faculty License | <input type="checkbox"/> Dental Reinstatement |
| <input type="checkbox"/> Dental Temporary Permit | <input type="checkbox"/> Dental Hygiene Temporary Permit | <input type="checkbox"/> 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