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 INSTRUCTIONS FOR ORAL & MAXILLOFACIAL SURGEON REGISTRATION OF PRACTICE

Pursuant to **18VAC60-21-310** every licensed dentist who practices as an oral and maxillofacial surgeon, as defined in § 54.1-2700 of the Code, shall register his practice with the board. An oral and maxillofacial surgeon who fails to register and continues to practice oral and maxillofacial surgery may be subject to disciplinary action by the board.

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 registration. 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 for an **oral & maxillofacial surgeon registration of practice is $175** 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. Please mail the completed application and fee to the address noted above.

____ 3. **Official Transcript 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.**

OMS Requirements listed in **60-27** Guidance on Sedation Permits, *effective February 3, 2022*

- The requirement for a sedation permit does not apply to an oral and maxillofacial surgeon (OMS) who maintains membership in the American Association of Oral and Maxillofacial Surgeons (AAOMS) and who provides the Board with reports that result from the periodic office examinations required by AAOMS (18VAC60-21-300 (A)).
- An OMS must hold a sedation permit if not a member of AAOMS. If the OMS holds a sedation permit and then becomes a member of AAOMS, the OMS must notify the Board within 30 days of becoming a member of AAOMS.
- An OMS, who is a member of AAOMS, must submit AAOMS office examination reports to the Board within 30 days of receipt.

Pursuant to **18VAC60-21-320. Profile of information for oral and maxillofacial surgeons.**

A. In compliance with requirements of § 54.1-2709.2 of the Code, an oral and maxillofacial surgeon registered with the board shall provide, upon initial request, the following information within 30 days:
   1. The address of the primary practice setting and all secondary practice settings with the percentage of time spent at each location;
   2. Names of dental or medical schools with dates of graduation;
   3. Names of graduate medical or dental education programs attended at an institution approved by the Accreditation Council for Graduate Medical Education, the Commission on Dental Accreditation, and the American Dental Association with dates of completion of training;
   4. Names and dates of specialty board certification or board eligibility, if any, as recognized by the Council on Dental Education and Licensure of the American Dental Association;

5. Number of years in active, clinical practice in the United States or Canada, following completion of medical or dental training and the number of years, if any, in active, clinical practice outside the United States or Canada;
6. Names of insurance plans accepted or managed care plans in which the oral and maxillofacial surgeon participates and whether he is accepting new patients under such plans;
7. Names of hospitals with which the oral and maxillofacial surgeon is affiliated;
8. Appointments within the past 10 years to dental school faculties with the years of service and academic rank;
9. Publications, not to exceed 10 in number, in peer-reviewed literature within the most recent five-year period;
10. Whether there is access to translating services for non-English speaking patients at the primary practice setting and which, if any, foreign languages are spoken in the practice; and
11. Whether the oral and maxillofacial surgeon participates in the Virginia Medicaid Program and whether he is accepting new Medicaid patients.

B. The oral and maxillofacial surgeon may provide additional information on hours of continuing education earned, sub-specialties obtained, and honors or awards received.
C. Whenever there is a change in the information on record with the profile system, the oral and maxillofacial surgeon shall provide current information in any of the categories in subsection A of this section within 30 days.

Pursuant to **18VAC60-21-340. Noncompliance or falsification of profile.**

A. The failure to provide the information required in 18VAC60-21-320 A may constitute unprofessional conduct and may subject the licensee to disciplinary action by the board.
B. Intentionally providing false information to the board for the profile system shall constitute unprofessional conduct and shall subject the licensee to disciplinary action by the board.

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APPLICATION FOR ORAL AND MAXILLOFACIAL SURGEON REGISTRATION OF PRACTICE 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. Please mail the completed application and fee to the address noted above.

I. GENERAL INFORMATION: PLEASE 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	____ ____ ____---____ ____--____ ____ ____ ____

***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.**

Date of Completion of Residency	Name of Completed OMS Residency Program. **Please attach a copy of the certificate of completion**:
_____ _____ _____ Month Day Year	

Virginia Dental License Number:

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 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

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4. 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

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5. 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.

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6. 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

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7. 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

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8. 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

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9. 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. [ ] Yes [ ] No

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11 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:_____

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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

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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

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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

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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

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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 oral and maxillofacial surgeons**. 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**