

## INSTRUCTIONS FOR REINSTATEMENT OF 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 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. **Documentation of continued competency:** To reinstate a certification that has been lapsed for more than one year, documentation of continued competency in the procedures for which the surgeon is certified is required.  
  
Continuing education hours and evidence of active practice in another state or in federal service, recent passage of a clinical competency examination, a refresher program offered by a program accredited by the Commission on Dental Accreditation of the American Dental Association or current certification by a professional credentialing board are considered in determining continuing competence. The optional employment verification form on page 5 may be used to document active practice. Completion of only home study, journal or internet courses is generally not sufficient to demonstrate continuing competence.
- \_\_\_ 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. 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. **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.

- \_\_\_\_\_ 9. **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](mailto: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.

- \_\_\_\_\_ 10. **Address of Record and Publicly Disclosable Address:** Consistent with Virginia law §54.1.2400.02 and the mission of the Department of Health Professions, addresses of licensees are made available to the public. Normally, the Address of Record is the publicly disclosable address. If you do not want your Address of Record to be made public, state law allows you to provide a second, publicly disclosable address. Typically, this other address is the work or practice address. If you would like for your Address of Record to be made available to the public, complete both sections with the same address.

**NOTES:**

- 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 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.



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](mailto:bodlicensing@dhp.virginia.gov)  
<https://www.dhp.virginia.gov/Boards/Dentistry/>

**REINSTATEMENT APPLICATION FOR CERTIFICATION TO PERFORM COSMETIC PROCEDURES**

**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<br>____/____/____<br>Month Day Year |  | Social Security Number or Virginia DMV control Number**<br>____-____-____ |                             |          |                  |
| Virginia Dental License Number:                   |  | Virginia Oral & Maxillofacial Surgical Practice Registration Number       |                             |          |                  |
| Name of Practice (if applicable):                 |  | Virginia Cosmetic Procedure Certification Number:                         | Date Certification Expired: |          |                  |

**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)

Have you practiced cosmetic dentistry (excluding the procedures noted in 18VAC60-20-300) since the expiration of your certification? If yes, give location:

- Reinstatement of 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 | Date Expired | License # | Reinstatement Date |
|------------|--------------|-----------|--------------------|

**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, <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 |
| 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.<br><br>_____  | [ ] 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.<br><br>_____                              | [ ] 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.<br><br>_____  | [ ] 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.<br><br>_____                              | [ ] 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](http://www.dhp.virginia.gov/dentistry).**

|                                 |               |
|---------------------------------|---------------|
| _____<br>Signature of Applicant | _____<br>Date |
|---------------------------------|---------------|



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## EMPLOYMENT VERIFICATION

(Optional Form)

(MUST BE COMPLETED BEFORE A NOTARY PUBLIC)

Name of Employing Dentist(s) or Agency: \_\_\_\_\_

Complete Mailing Address: \_\_\_\_\_

Telephone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Email Address \_\_\_\_\_

"I, \_\_\_\_\_ DDS / DMD / agency representative,  
(Print name & Title of the Employing Dentist or Agency Representative)

certify that \_\_\_\_\_, was employed by me as a \_\_\_\_\_  
(Print Applicant/Employee Name) (Print Job Title)

\_\_\_\_\_ from \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_, in the clinical, ethical and legal  
Month Day Year Month Day Year

practice of a \_\_\_\_\_.

\_\_\_\_\_  
Dentist's/Agency Representative Signature Date

State of \_\_\_\_\_

County/City of \_\_\_\_\_

Sworn and subscribed to, before me, this \_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_.  
Day Month Year

My commission expires on \_\_\_\_\_.  
Month Day Year

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

SEAL/STAMP

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



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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 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                |
| <input type="checkbox"/> Certification to Perform Cosmetic Procedures |   |  |

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](mailto: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