INSTRUCTIONS FOR REINSTATEMENT OF DENTAL LICENSE

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. **Reinstatement Application**: Please be sure that all information is completed on the application.

2. **Fee for lapse of license**: The reinstatement fee for a dental license is **$500** and must be paid with a check or money order, made payable to the **Treasurer of Virginia**.

   **Fee for license revocation or suspension**: The reinstatement fee for a previously revoked dental license is **$1,000** and the fee for a previously suspended dental license is **$750**.

   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. **Form B Chronology**: List ALL activities since expiration of your license. Resumes and curriculum vitae are not accepted as substitutes for completing the chronological listing and will not be considered. (Form B may be emailed/faxed/mailed to the Board.)

4. **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. (May be mailed to the Board or emailed to the Board directly from the issuing state official representative.)

5. **Continuing Education**: You must submit documentation of having completed 15 hours of continuing education (CE) for each year the license was lapsed, up to a total of 45 hours in the 36 months immediately preceding the application for reinstatement. Course sponsors and content must meet the requirement in 18VAC60-21-250 of the Regulations Governing the Practice of Dentistry. Of the required hours, at least 15 must be earned in the most recent 12 months immediately preceding your application and the remainder within the 36 months immediately preceding the application. Original documents or copies are accepted.

   For example, the three period immediately preceding an application received on October 15, 2018 began on October 16, 2015. The three calendar years for this example application are:

   - **First year**: October 16, 2015 to October 15, 2016
   - **Second year**: October 16, 2016 to October 15, 2017
   - **Third year**: October 16, 2017 to October 15, 2018

   Submitted CE documentation must include the following:

   - Your name
   - Name of course completed
   - If the subject matter of the course is not evident in the title, you must also submit the sponsor’s course description.
   - Date(s) in which you completed the course
   - Name of the course sponsor; and
   - The number of CE credit hours earned

Reinstatement Dental Application Revised August 2020
6. **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](http://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). *(Must be mailed & received at the Board in its original sealed envelope.)*

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 [www.dhp.virginia.gov/dentistry](http://www.dhp.virginia.gov/dentistry).

8. **Name Change:** Documentation must be provided to show each name change(s) if your name has ever been changed from the most recent time you held an active license in Virginia or were licensed in other jurisdictions or other than what is on record with the Virginia Board of Dentistry. Photocopies of marriage licenses or court orders are accepted. *(May be mailed, faxed or emailed to the Board.)*

9. **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 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:**

- To qualify for reinstatement of a license, the applicant must include documentation in the application sufficient to demonstrate continuing competence. 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 11 may be used to document active practice. Completion of only home study, journal or internet courses is generally not sufficient to demonstrate continuing competence.

- If your Virginia license has not been reinstated within six months of the Board’s receipt of the application, certain portions of the application may need to be resubmitted before your application can be reviewed.

- To receive notice that your application has been delivered to the Board, it is suggested that the complete packet be mailed by “Certified Mail-Return Receipt Requested” or with “Delivery Confirmation”.

- 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.
APPLICATION FOR REINSTATEMENT OF DENTAL LICENSE 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)

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<th>Name: Last*</th>
<th>First</th>
<th>Middle/Maiden</th>
<th>Suffix</th>
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<th>Address of Record (Mailing Address)</th>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
<th>Telephone Number</th>
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<tr>
<th>Publicly Disclosable Address</th>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
<th>Telephone Number</th>
</tr>
</thead>
</table>

Email Address: 
Fax Number: 

Date of Birth

Month / Day / Year

Social Security Number or Virginia DMV Control Number on record**

__ __ __ __--__ __ __ __ __

License Number

Date of Expiration

Name at time of Original Licensure:* 

Please check below, if applicable:

☐ REINSTATEMENT REQUESTED DUE TO LAPSE OF LICENSE

☐ 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

<table>
<thead>
<tr>
<th>FEE AMOUNT</th>
<th>APPLICANT #</th>
<th>DATE OF REINSTATEMENT</th>
<th>LICENSE #</th>
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Reinstatement Dental Application Revised August 2020
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 dentistry since the expiration of your license in the Commonwealth of Virginia or in another jurisdiction? If “YES”, give location. __________________________

4. Has any of your work since the expiration of your dental license been in any field other than the practice of dentistry? If “YES”, give details, jurisdictions(s) and date(s).
________________________________________________________________________
________________________________________________________________________

5. List all jurisdictions in which you currently hold or have ever held a license / registration / certification to practice dentistry or as any other health care professional:

<table>
<thead>
<tr>
<th>Jurisdiction</th>
<th>License Number</th>
<th>Date Issued</th>
<th>Expiration Date</th>
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6. Have you ever been convicted of a violation of or pled Nolo Contendere to any federal, state or local statute, regulation or ordinance, or entered into any plea bargaining relating to a felony or misdemeanor? (Excluding traffic violations, except convictions for driving under the influence.) 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. [ ] Yes [ ] No

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.

- 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. A. Within the past five years, have you exhibited any conduct or behavior that could call into question your ability to practice in a competent and professional manner? If “YES”, please provide a full explanation. [ ] Yes [ ] No

___________________________________________________________________________
___________________________________________________________________________
B. Within the past five years, have you sought or been directed to seek treatment for your conduct or behavior? If "YES", please provide a full explanation and any associated orders or letters.  

____________________________________________________________________

____________________________________________________________________

[ ] Yes  [ ] No

2. A. Within the past five years, have you been disciplined by any entity? If "YES", please provide a full explanation and any associated orders or letters from the entity.  

____________________________________________________________________

____________________________________________________________________

B. Within the past five years, have you sought or been directed to seek treatment for your conduct or behavior? If "YES", please provide a full explanation and any associated orders or letters.  

____________________________________________________________________

____________________________________________________________________

[ ] Yes  [ ] No

3. Do you currently have any physical condition or impairment that affects or limits your ability to perform any of the obligations and responsibilities of professional practice in a safe and competent manner?  

“Currently” means recently enough so that the condition could reasonably have an impact on your ability to function as a practicing dentist. If "YES", please provide a full explanation. NOTE: The Board may request a letter from your current treatment provider addressing your current condition and ability to safely practice. You may consider providing this documentation with your application, or have your provider send this documentation directly to the Board.  

____________________________________________________________________

____________________________________________________________________

[ ] Yes  [ ] No

4. Do you currently have any mental health condition or impairment that affects or limits your ability to perform any of the obligations and responsibilities of professional practice in a safe and competent manner?  

“Currently” means recently enough so that the condition could reasonably have an impact on your ability to function as a practicing dentist. If "YES", please provide a full explanation. NOTE: The Board may request a letter from your current treatment provider addressing your current condition and ability to safely practice. You may consider providing this documentation with your application, or have your provider send this documentation directly to the Board.  

____________________________________________________________________

____________________________________________________________________

[ ] Yes  [ ] No

5. Do you currently have any condition or impairment related to alcohol or other substance use that affects or limits your ability to perform any of the obligations and responsibilities of professional practice in a safe and competent manner?  

“Currently” means recently enough so that the condition could reasonably have an impact on your ability to function as a practicing dentist. If "YES", please provide a full explanation. NOTE: The Board may request a letter from your current treatment provider addressing your current condition and ability to safely practice. You may consider providing this documentation with your application, or have your provider send this documentation directly to the Board.  

____________________________________________________________________

____________________________________________________________________

[ ] Yes  [ ] No
6. Within the past 5 years, have any conditions or restrictions been imposed upon you or your practice to avoid disciplinary action by any entity?

[ ] Yes [ ] No

If “YES”, please provide a full explanation and any associated orders or letters from the entity.

NOTE: The Board may request a copy of a current participation contract and summary of compliance and/or documentation of successful completion. You may consider providing this documentation with your application, or have the program send this documentation directly to the Board.

____________________________________________________________________
____________________________________________________________________

[ ] Yes  [ ] No

VIRGINIA BOARD OF DENTISTRY
APPLICATION AFFIDAVIT

I hereby certify that I am the person referred to in the foregoing 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 www.dhp.virginia.gov/dentistry, 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 _______________________________
FORM B
CHRONOLOGY

NAME OF APPLICANT: ____________________________________________________________

Every applicant must provide a complete chronological, personal and professional history of all activities you have engaged in since the expiration of your license, including teaching positions, all periods of non-professional activity or employment, volunteer work and all periods of unemployment. Curriculum vitae and resumes are not accepted as substitutes for completing the chronological listing and will not be considered.

Form B may be photocopied if additional space is needed.

<table>
<thead>
<tr>
<th>FROM</th>
<th>TO</th>
<th>POSITION/ACTIVITY</th>
<th>Employer/Contact Person for practice verification and the person’s Complete Address, and Telephone #</th>
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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.

<table>
<thead>
<tr>
<th>I am making application for licensure in Virginia by:</th>
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<tbody>
<tr>
<td>[ ] Examination for Dental License</td>
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<tr>
<td>[ ] Credentials for Dental License</td>
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<tr>
<td>[ ] Dental Faculty License</td>
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<tr>
<td>[ ] Dental Temporary Permit</td>
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<tr>
<td>[ ] Examination for Dental Hygiene License</td>
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<tr>
<td>[ ] Credentials for Dental Hygiene License</td>
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<tr>
<td>[ ] Dental Hygiene Faculty License</td>
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<tr>
<td>[ ] Dental Hygiene Temporary Permit</td>
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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 denbd@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:

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________      ____________  _______________________
Signature    Title    Date

________________________________
Print Name

**SEAL**
NAME OF LICENSEE: ________________________  LICENSE NUMBER: ________________

VIRGINIA BOARD OF DENTISTRY CONTINUING EDUCATION COURSES
Complete all information and include all required supporting documents.

Pursuant to 18VAC60-21-250(B) of the Regulations Governing the Practice of Dentistry, CE programs shall be clinical courses in dentistry or dental hygiene or supportive of clinical services. Courses not acceptable include, but are not limited to: estate planning, financial planning, investments, business management, marketing & personal health.

<table>
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<tr>
<th>DATE</th>
<th>NAME OF COURSE</th>
<th>APPROVED SPONSOR</th>
<th>NUMBER OF EARNED HOURS</th>
<th>BOARD REVIEW</th>
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TOTAL HOURS________________
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, ___________________________________________ D.D.S./D.M.D./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
practice of a ____________________________.

Dentist’s/Agency Representative Signature ___________________________ Date ______________

State of ______________________________

County/City of ______________________________

Sworn and subscribed to, before me, this _________ day of __________, ______.

My commission expires on ____________________________

Signature of Notary Public __________________________________

SEAL/STAMP

____________________________

Print Name