



## INSTRUCTIONS FOR RESTRICTED VOLUNTEER DENTAL HYGIENE 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. **Application:** Please be sure that all information and questions are completed on the application.
- \_\_\_\_\_ 2. **Application Fee:** The fee for a **restricted volunteer dental hygiene license is \$25** 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 18VAC60-25-30(F), all fees are non-refundable. Your application will not be reviewed until you have submitted payment.
- \_\_\_\_\_ 3. **Form A:** Certification of Dental Hygiene Supervisor -a restricted volunteer dental hygiene shall practice only in a public health or community free clinic under the direction of a dentist who holds an unrestricted license in Virginia and only treat patients who have been screened by the approved clinic and are eligible for treatment.
- \_\_\_\_\_ 4. **Form B Chronology:** list **ALL** activities, personal and professional, to include all time periods of employment and unemployment, since receiving degree. (*Resumes and curriculum vitae are not accepted as substitutes for completing the chronological listing Form B and will not be considered.*) (**Form B may be email/ fax/mail to the Board**)
- \_\_\_\_\_ 5. **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 dental hygienist or as another health care professional. Copies of permits are not accepted. Certifications cannot be older than 6 months from date prepared. (**May be mail to the Board or emailed to the Board directly from the issuing state official representative. 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.**)
- \_\_\_\_\_ 6. **NPDB:** **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 the report. ***This report from NPDB is required from all applicants, without exception pursuant to Regulation 18VAC60-25-130A(3). (Must be mail & 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 the 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, 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. **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:**

- **A person holding a restricted volunteer dental hygiene license shall practice only in a public health or community free clinic under the direction of a dentist who holds an unrestricted license in Virginia and only treat patients who have been screened by the approved clinic and are eligible for treatment.**
- Completed applications cannot be accessed or edited once they have been submitted.
- If your Virginia License is not issued within six months of the date of the NPDB (National Practitioner Databank) Self Query Report and certification of state licensure, you will be asked to submit a current NPDB Self Query Report and current state licensure certification before your application can be reviewed.
- To receive notice that your supporting documents have been delivered to the board, it is suggested that the documents be mailed by Fed-Ex or UPS 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.

**Pursuant to Regulation 18VAC60-25-170. Voluntary practice.**

**A. Restricted volunteer license.**

1. In accordance with § 54.1-2726.1 of the Code, the board may issue a restricted volunteer license to a dental hygienist who:
  - a. Held an unrestricted license in Virginia or another jurisdiction of the United States as a licensee in good standing at the time the license expired or became inactive;
  - b. Is volunteering for a public health or community free clinic that provides dental services to populations of underserved people;
  - c. Has fulfilled the board's requirement related to knowledge of the laws and regulations governing the practice of dentistry and dental hygiene in Virginia;
  - d. Has not failed a clinical examination within the past five years;
  - e. Has had at least five years of active practice in Virginia; another jurisdiction of the United States or federal civil or military service; and
  - f. **Is sponsored by a dentist who holds an unrestricted license in Virginia.**
2. A person holding a restricted volunteer license under this section shall:
  - a. Practice only under the direction of a dentist who holds an unrestricted license in Virginia;
  - b. Only practice in public health or community free clinics that provide dental services to underserved populations;
  - c. Only treat patients who have been screened by the approved clinic and are eligible for treatment;
  - d. Attest on a form provided by the board that he will not receive remuneration directly or indirectly for providing dental services; and
  - e. Not be required to complete continuing education in order to renew such a license.
3. A restricted volunteer license granted pursuant to this section shall expire on June 30 of the second year after its issuance or shall terminate when the supervising dentist withdraws his sponsorship.
4. A dental hygienist holding a restricted volunteer license issued pursuant to this section is subject to the provisions of this chapter and the disciplinary regulations that apply to all licensees practicing in Virginia.

## APPLICATION FOR RESTRICTED VOLUNTEER DENTAL HYGIENE 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: PLEASE COMPLETE ALL SECTIONS (PRINT OR TYPE)

Name: Last*		First	Middle/Maiden	Suffix
Address of record(Mailing Address)		City	State	Zip Code
Publicly Disclosable Address		City	State	Zip Code
Email address		Fax #		
Date of Birth ____/____/____ Month Day Year		Social Security Number or Virginia DMV control Number** ____-____-____		
Graduation Date ____/____/____ Month Day Year	Professional Degree	School	City	State

### APPLICANTS DO NOT USE SPACES BELOW THIS LINE – FOR OFFICE USE ONLY

DATE RECEIVED	CHRONOLOGY (FORM B)	NATIONAL PRACTITIONER DATA BANK
---------------	---------------------	---------------------------------

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 AMOUNT	APPLICANT #	RESTRICTED VOLUNTEER LICENSE #	DATE ISSUED
------------	-------------	--------------------------------	-------------

**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. List in chronological order the dental hygiene school(s) attended:

Begin Date	Year Completed	Name of Dental Hygiene School	Degree/Certificate Awarded
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

4. List all licenses/registrations/certificates which you have been issued to practice dental hygiene or any other health care professional.

Jurisdiction	Number	Type	Date Issued	Exp. Date
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

5. Have you ever been denied a license, or the privilege of taking a dental hygiene licensure/competency examination by a licensing authority? If "YES", give detail(s), jurisdiction(s) and date(s). [ ] Yes [ ] No

\_\_\_\_\_  
\_\_\_\_\_

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 misdemeanor (excluding traffic violations, except convictions for driving under the influence)? **"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.

\_\_\_\_\_  
\_\_\_\_\_

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.	<p>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? Please provide a full explanation.</p> <p>_____</p> <p>_____</p>	[ ] Yes [ ] No
	<p>B. Within the past five years, have you sought or been directed to seek treatment for your conduct or behavior?</p> <p>_____</p> <p>_____</p>	[ ] Yes [ ] No
2.	<p>Within the past five years, have you been disciplined by any entity?</p> <p>A. Please provide a full explanation and any associated orders or letters from the entity.</p> <p>_____</p> <p>_____</p>	[ ] Yes [ ] No
	<p>B. Within the past five years, have you sought or been directed to seek treatment for your conduct or behavior.</p> <p>_____</p> <p>_____</p>	[ ] Yes [ ] No
3.	<p>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?</p> <p><small>**“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. <b>Note:</b> 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.</small></p> <p>_____</p> <p>_____</p>	[ ] Yes [ ] No
4.	<p>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?</p> <p><small>**“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. <b>Note:</b> 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.</small></p> <p>_____</p> <p>_____</p>	[ ] Yes [ ] No
5.	<p>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?</p> <p><small>**“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. <b>Note:</b> 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.</small></p> <p>_____</p> <p>_____</p>	[ ] Yes [ ] No
6.	<p>Within the past five years, have any conditions or restrictions been imposed upon you or your practice to avoid disciplinary action by any entity?</p> <p>If “YES”, please provide a full explanation and any associated orders or letters from the entity. <b>Note:</b> 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.</p> <p>_____</p> <p>_____</p>	[ ] 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, I declare under penalty of perjury that my answers and all statements made by me herein are true and correct. Should I furnish any false information on this application, I hereby agree that such act shall constitute cause for the denial, suspension or revocation of my license to practice dental hygiene 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](http://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.

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
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)  
[denbd@dhp.virginia.gov](mailto:denbd@dhp.virginia.gov)  
[www.dhp.virginia.gov/dentistry](http://www.dhp.virginia.gov/dentistry)

**FORM A**  
**CERTIFICATION OF RESTRICTED DENTAL HYGIENE SUPERVISOR**

**INSTRUCTIONS:** You are required to be sponsored by a dentist who holds an unrestricted license in Virginia in order to hold a restricted dental hygiene volunteer license.

**TO BE COMPLETED BY APPLICANT:**

**NAME OF APPLICANT:** \_\_\_\_\_ **for Dental Hygiene Restricted Volunteer License**

1. Name and physical address of the clinic you will be volunteering at:

\_\_\_\_\_  
\_\_\_\_\_

2. Please give the month and year when you were last in active practice.

Month \_\_\_\_\_ Year \_\_\_\_\_

3. How many years have passed since your last date of service: \_\_\_\_\_

**TO BE COMPLETED BY SPONSOR:**

By affixing my signature below, I verify that I will review the quality of care rendered by the above named applicant who will only treat patients who have been screened by the approved clinic and are eligible for treatment. I will directly observe patient care being provided and review all patient charts. Such supervision shall be noted in patient charts and maintained in accordance with 18VAC60-21-90 as required by 18VAC60-21-230.D(3) of the Regulations Governing the Practice of Dentistry.

\_\_\_\_\_  
Signature of Sponsor

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

\_\_\_\_\_  
Title

\_\_\_\_\_  
Virginia License Number

\_\_\_\_\_  
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)  
[denbd@dhp.virginia.gov](mailto:denbd@dhp.virginia.gov)  
[www.dhp.virginia.gov/dentistry](http://www.dhp.virginia.gov/dentistry)

## FORM B CHRONOLOGY

APPLICANT NAME: \_\_\_\_\_

Every applicant must provide a complete chronological, personal and professional history of all activities you have engaged in since receiving your degree or certification, 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 copies are needed.*

FROM Month/Year	TO Month/Year	Employer/Location of Private Practice, Complete Address, Contact Person & Telephone #	Position Held





Virginia Department of  
**Health Professions**  
Board of Dentistry

9960 Mayland Drive, Suite 300  
Henrico, Virginia 23233  
(804) 367-4538 (Tel)  
(804) 698-4266 (eFax)  
[denbd@dhp.virginia.gov](mailto:denbd@dhp.virginia.gov)  
[www.dhp.virginia.gov/dentistry](http://www.dhp.virginia.gov/dentistry)

## FORM C CERTIFICATION OF DENTAL HYGIENE 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 \_\_\_\_\_ Month \_\_\_\_\_ Date \_\_\_\_\_ Year. by the State of \_\_\_\_\_.

\_\_\_\_\_ 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](mailto: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: \_\_\_\_\_

**SEAL**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Title

\_\_\_\_\_  
Date

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