



## INSTRUCTIONS FOR A TEMPORARY RESIDENT'S 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 **temporary resident's license by examination is \$60** 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. **Form B Chronology:** List **ALL** activities, personal and professional, 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.*) (Form B may be email/fax/mail to the Board.)
- \_\_\_\_\_ 4. **Official Transcript (if you have completed a Degree/Certificate program):** Final **original** transcript bearing SEAL, date degree received 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 letter that addresses the coursework and clinical training that you completed, signed by the Program Director, is required. (May be mail/emailed to the Board. An official transcript –must be on original official school paper (sealed) or an online version that Board staff must download from the college, e-scrip or university website.)
- \_\_\_\_\_ 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 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 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. **Form D Recommendation Letter:** Recommendation from the dean of the dental school or the director of the accredited advanced dental education program specifying the applicant's acceptance as an intern, resident or post-doctoral certificate or degree candidate. The beginning and ending dates of the internship, residency or post-doctoral program must be specified. (May be mailed to the Board or emailed to the Board directly from the school/agency official representative.)
- \_\_\_\_\_ 7. **NBDE:** An **original** grade card **indicating 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. (Must be mail to the Board or if applicable, you must contact the testing agency to request that your test results be made available to the Virginia Board of Dentistry via online access portal.)
- \_\_\_\_\_ 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](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 mail & received at the Board in its original sealed envelope.)

- \_\_\_\_\_ 9. 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).
- \_\_\_\_\_ 10. **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. (May be mail/fax/email to the Board.)
- \_\_\_\_\_ 11. **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:**

- Completed applications cannot be accessed or edited once they have been submitted.
- If your Virginia License is not issued within 6 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.
- **The temporary license permits the holder to practice only in the hospital or outpatient clinics that are recognized parts of an advanced dental education program. The temporary license holder is prohibited from practicing outside of the advanced dental education program.**
- A Virginia address must be provided before a Temporary Resident's License can be issued.
- 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.

**Related contact information:**

**National Practitioner Data Bank**  
P.O. P.O. Box 10832  
Chantilly, VA 20153  
1-800-767-6732  
[www.npdb.hrsa.gov](http://www.npdb.hrsa.gov)

**National Board Scores**  
**Joint Commission on National Dental Examinations**  
211 East Chicago Avenue  
Chicago, IL 60611-2678  
1-800-232-1694  
[www.ada.org/jcnde/examinations](http://www.ada.org/jcnde/examinations)



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)

## APPLICATION TEMPORARY RESIDENT'S 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)

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** ____-____-____			
DDS/DMD GRADUATION DATE ____/____/____ Month Day Year	PROFESSIONAL DEGREE		CODA/CDAC APPROVED DENTAL SCHOOL/CITY/STATE			
RESIDENCY/SPECIALTY GRADUATION DATE ____/____/____ Month Day Year	RESIDENCY/SPECIALTY DEGREE or CERTIFICATE		CODA/CDAC APPROVED DENTAL SCHOOL/CITY/STATE			
<b>APPLICANTS DO NOT USE SPACES BELOW THIS LINE – FOR OFFICE USE ONLY</b>						
DATE RECEIVED	CHRONOLOGY (FORM B) ____	NATIONAL PRACTITIONER DATA BANK		NATIONAL BOARD		
TRANSCRIPT	RECOMMENDATION FROM DEAN/DIRECTOR (FORM D)		CERTIFICATION (LICENSE FROM OTHER STATES FORM C OR LETTER)			
<b>*Name change:</b> 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.						
<b>**In accordance with § 54.1-116 of the Code of Virginia,</b> you are required to submit your Social Security Number or your control number issued by the <u>Virginia Department of Motor Vehicles</u> . 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 #		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) ☐ Yes ☐ No 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.
  
2. Are you active-duty military? If "YES", include a copy of your official military orders with the ☐ Yes ☐ No application.
  
3. List in chronological order including months and years, the dental school(s) attended (include specialty and advanced programs):
 

Months & Years	Name of Dental School (ADA-CODA)	Passed/Failed
_____ to _____	_____	_____
_____ to _____	_____	_____
_____ to _____	_____	_____
  
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.
 

Jurisdiction	Number	Type	Date Issued	Exp. Date
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
  
5. Have you ever been dropped, suspended, expelled, or disciplined by any school or college for any ☐ Yes ☐ No cause whatever? If "YES", give detail(s), jurisdiction(s) and date(s).
 

\_\_\_\_\_

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

\_\_\_\_\_

\_\_\_\_\_
  
7. Have you ever been convicted of a violation or plead Nolo Contendere, to any federal, state or local ☐ Yes ☐ No 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). "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."

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.

\_\_\_\_\_

\_\_\_\_\_
  
8. 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: \_\_\_\_\_

\_\_\_\_\_

# TEMPORARY RESIDENT'S LICENSE Application Page 3

## 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. [ ] 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. [ ] 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 from the entity. [ ] 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? [ ] Yes [ ] No

\*"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.

\_\_\_\_\_

\_\_\_\_\_
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? [ ] Yes [ ] No

\*"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.

\_\_\_\_\_

\_\_\_\_\_
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? [ ] Yes [ ] No

\*"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.

\_\_\_\_\_

\_\_\_\_\_

6. Within the past five 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 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.

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

**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 [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.

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

\_\_\_\_\_  
Date



## 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 additional space is needed.*

FROM Month/Year	TO Month/Year	POSITION/ACTIVITY	Employer/Contact Person for practice verification and the person's Complete Address, and Telephone #

## 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"/> Temporary Resident's License           |  |

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](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





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 D**  
**RECOMMENDATION MEMORANDUM**

**MEMORANDUM:**

TO: Virginia Board of Dentistry

FROM: Dean of dental school or the director of the accredited graduate program

Name of Training Institute: \_\_\_\_\_

Complete Mailing address: \_\_\_\_\_

Telephone: \_\_\_\_\_

This is to certify that \_\_\_\_\_ will be enrolled in \_\_\_\_\_  
Name of resident Name of Program

\_\_\_\_\_ at \_\_\_\_\_,  
Name of dental school Street Address

\_\_\_\_\_  
City, State and Zip Code

From \_\_\_\_\_ with an expected completion of date of \_\_\_\_\_  
(Month/Day/Year) (Month/Day/Year)

Dr. \_\_\_\_\_ is a graduate of \_\_\_\_\_  
Name of resident Dental School

**SEAL**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Name Printed

\_\_\_\_\_  
Title

\_\_\_\_\_  
Date