



**GOVERNMENT OF
THE VIRGIN ISLANDS OF THE UNITED STATES**

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**DEPARTMENT OF HEALTH
1303 HOSPITAL GROUND, SUITE 10, ST. THOMAS, U.S.V.I. 00802**

**VIRGIN ISLANDS
BOARD OF DENTAL EXAMINERS**

Ph. [REDACTED] x [REDACTED]
Fax: 340-777-4001
Direct Line: [REDACTED]

Dear Applicant:

We received your request for information concerning dental licensure in the U.S. Virgin Islands.

The Clinical Examination consists of the following areas: Surgery, Periodontics and Operative. The Computerized National Board Part II must be taken in whatever state applicant resides, and a request must be made to have scores transfer to the Virgin Islands Board of Dental Examiners. This should be done prior to coming to the Virgin Islands to take the Clinical Examination.

The National Board of Dental Examination Part II is waived to applicants who have provided proof of passing the National Board **no** longer than **two** years prior to taking the Virgin Islands Board examination.

Examinations are scheduled through the VI Department of Health.

If an applicant needs to take the Computerized National Board Part II they should contact the American Dental Association, 211 East Chicago Avenue, Suite 600, Chicago, IL 60611-2637.

Should you have any questions, please contact Mrs. Cora Lapuz-Adrovel at [REDACTED] or e-mail: [REDACTED]

The following documentations must be submitted at least six (6) weeks (April 30th or September 30th) prior to the examination schedule date.

- An application is considered complete when all required documents, background information and fees are on file with the Board's office.
- A recent photograph of passport size, autographed across the back.
- A certified check, bank money order or U.S. Postal money order in the amount of **\$65.00**, payable to Government of the Virgin Islands. **This fee is non-refundable.**
- Chronology of professional activities from graduation to time of application.
- Proof of graduation from an ADA accredited school of Dentistry (copy of Diploma).
- Be twenty-one years of age or older. Copy of birth certificate or similar proof of age required.
- Two letters of character reference from qualified dental practitioners in the state where applicant is from.
- Notarized statement, signed by applicant, attesting to non-addiction to intemperate use of alcoholic stimulants or narcotic drugs.
- Proof of National Board scores. Original of the Final Report of scores is required.
- Authorization for Release of Information
- Verification of state licensure forms
- Licensure History: Have you ever applied for a license to practice dentistry in another state(s), territory, or the District of Columbia. If yes, list all areas or states. (Submit copy of current state license(s))
- Mandatory background check required from the Professional Background Information Services (PBIS); all fees must be paid by the applicant. The address is as follows:

Professional Background Information Services
23460 North 19th Avenue, Suite 225
Phoenix, Arizona 85027
Tele: 602-861-5867 - Fax: 602-861-9656

NOTE: If you cancel your original examination date, you will need to notify the Board **six weeks** prior to the next scheduled examination of your intention.

We suggest that if you so desire, you may contact local dentists, who may help you secure patients.

Any other additional information may be obtained from the Dental Board Office at [REDACTED] or [REDACTED] extension [REDACTED].

Sincerely,

V.I. Board of Dental Examiners



BOARD OF DENTAL EXAMINERS FOR THE U.S. VIRGIN ISLANDS

APPLICATION FOR ADMISSION TO PROFESSIONAL EXAMINATION

Filing Deadline - April 30 for June Exam and September 30 for November Exam

E-mail _____

Cell _____

Print Name _____ Phone _____

Address _____

City _____ State _____ Zip Code _____

Home Address _____ City _____ State _____ Zip Code _____

Birth date ____ / ____ / ____ Birthplace _____

Social Security No. _____

Citizen of _____ (If you were not born in the United States, your own **original certificate of Citizenship or of Declaration of Intention or Derivative Citizenship must be submitted. Document will be returned by certified mail).**)

High School _____ Location _____

College _____ Location _____

Professional School _____ Location _____

Date graduated ____ / ____ / ____ Degree received _____

If employed, give name and address of employer _____

Has any State rejected your application or revoked your professional license? (Yes or No) _____
(If "Yes" attach explanation)

Have you ever been convicted of any crime or unprofessional conduct? (Yes or No) _____
(If "Yes" attach explanation)

Examination held second **week** in **June** and **November**, state time preferred _____.

New address _____

*Do Not Write Below
Fee Stamp*

*Do Not Write Below
Fee Stamp*

App. Of Qualifications

PRE. BY _____

DATE _____

PROF. BY _____

EXP. BY _____

DATE _____

Approval of License

BY _____

DATE _____

BY _____

LIC. NO. _____

TO CAND. _____

**ADDRESS _____

AFFIDAVIT

**PASTE PHOTOGRAPH
SECURELY IN THIS SPACE**

**Write signature on light portion
of photograph, not across features**

Note: Any false or misleading information in or in connection with any application may be cause for debarment on the ground of lack of good moral character.

State of _____)
) ss
County or City of _____)

The undersigned, being duly sworn deposes and says that he/she is the person who executed this application; that the statements herein contained are true in every respect; that he/she has never been convicted of a crime; that he/she has never been expelled from any professional society; that he/she has not suppressed any information that might affect this application; that he/she will conform to the ethical standards of conduct in his/her profession; and that he/she has read and understands this affidavit.

*A crime would include either a felony or a misdemeanor.

(Signature of Applicant)

Date of photograph

Sworn to before me this ____ day of _____ 20__

Notary Public

Commissioner of Deeds

My Commission expires on ____ / ____ / 20__

PERSONAL SIGNATURE OF PERSONS RECOMMENDING APPLICANT

This certifies that I have been personally acquainted with the applicant since the year(s) indicated opposite my name; that I believe him/her to be of a good moral character and worthy of licensure in the U.S. Virgin Islands; and that any reservations I may have about the applicant I agree to send by certified mail in a confidential letter to the Board of Dental Examiners of the U.S. Virgin Islands.

<u>Please Print Name</u>	<u>Personal Signature</u>	<u>Address</u> (Including street & city)	<u>Known Since</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

(Signatures are required by not fewer than three citizens unrelated to applicant who must be licensed in the profession for which an applicant wishes to be examined or who are members of the staff of the professional school.)

**Return Application to: V.I. Board of Dental Examiners
Department of Health
1303 Hospital Ground, Suite 10
St. Thomas, V.I. 00802**



AUTHORIZATION FOR RELEASE OF INFORMATION

In order for the Virgin Islands Board of Dental Examiners to assess and verify my educational background and professional qualifications, I hereby authorize the Board to:

- make inquiries concerning such information about me to my employers (past and present), hospital(s), institution(s) or organization(s), my references, all governmental agencies and instrumentalities (local, state, federal or foreign);
- authorize the release of such information and copies of related records and documents to the Virgin Islands Board of Dental Examiners;
- authorize the Board to disclose to such persons, employers, hospitals, institutions, organizations, references, governmental agencies and instrumentalities identifying and other information about me sufficient to enable the Board to make such inquiries;
- release from liability all those who provide information to the Virgin Islands Board of Dental Examiners in good faith and without malice in response to such inquiries.

Signature

Date

Print Name

Subscribed and sworn to before me this ____ day of _____ 20__

Notary Public

My Commission Expires



VERIFICATION OF LICENSURE

APPLICANT IS REQUIRED TO COMPLETE THIS SECTION OF THE FORM AND MAIL TO EACH STATE BOARD IN WHICH HE/SHE ARE NOW OR HAVE EVER BEEN LICENSED TO PRACTICE DENTISTRY. IF NEEDED, YOU MAY XEROX THIS FORM FOR ADDITIONAL COPIES.

To Whom It May Concern:

I am being considered for Dental licensure in the Territory of the U.S. Virgin Islands. The V.I. Board of Dental Examiners requires that this form be completed by each state in which, I am now or have ever been licensed to practice my profession. Enclosed is my authorization for release of information. **Please forward this form directly to: VI Board of Dental Examiners, Department of Health, 1303 Hospital Ground, STE 10, St. Thomas, VI 00802.**

Applicant's Signature

Name: _____

Address: _____

My License No. in your State: _____

THIS SECTION IS TO BE COMPLETED AND SIGNED BY AN OFFICIAL OF THE STATE BOARD AND RETURNED DIRECTLY TO THE VI BOARD OF DENTAL EXAMINERS.

State of: _____

Full Name of Licensee: _____

License No.: _____ Issuance Date: _____

Is license current and in good standing? If NO, furnish details. _____

Has any disciplinary action ever been taken against the above named Dentist? If YES, furnish details.

Comments, if any: _____

BOARD SEAL

Signed: _____

Title: _____

State Board: _____

Date: _____



**VIRGIN ISLANDS BOARD OF DENTAL EXAMINERS
STATEBOARD LICENSING EXAMINATION
(Please read carefully)**

General Information on Application For Clinical Examination

1. Good professional demeanor is expected of all candidates.
2. All instructions presented will be strictly adhered to.
3. Candidates will provide their own patients.
4. It is recommended that candidates arrive at least one week prior to examination in order to secure suitable patients.
5. It is recommended that all candidates provide back-up patients should their primary patient be found not acceptable.
6. All candidates must have all requirements at the beginning of the examination.
7. A complete medical history of each patient is required.
8. Candidates are responsible for adhering to infection control procedures as outlined by the Center for Disease Control (CDC). Violation of this will result in penalties or failure of the entire examination.
9. Candidates are expected to present themselves in a neat and clean professional manner.
10. Time limits are strictly observed with failure resulting if the limits are exceeded. The only extension possible is if the Examiner(s) require an unusual amount of time to confer during evaluation.

Time Allotment

- | | |
|----------------|------------|
| • Surgery | 30 minutes |
| • Periodontics | 60 minutes |
| • Operative | 75 minutes |

NOTE: Total examination time is 3 ½ hours: 9:00 A.M. - 12:30 P.M.

11. Candidates must pass each of the three areas (Surgery, Periodontics and Operative) to qualify for licensure.
12. Any cheating or attempts to deceive the Examiner(s) will result in automatic failure.

13. Each patient must have a signed and notarized consent to treat form.
14. Candidates must treat patients with careful regard for the patient's health and well-being. Penalties will be assessed for inappropriate use of anesthesia or radiation, poor infection control, disregard for medical conditions, inordinate trauma to soft or hard tissue during treatment, or any other violation of reasonable standards of care.
15. Upon presentation of a patient to the Examiner(s), the Examiner(s) reserve the right to disapprove of a patient, a tooth, or an area for treatment. The Examiner(s) may also assign a different tooth or area for the same patient. Therefore, it is recommended that the candidate provide a back-up patient for each procedure.
16. If at any point during the examination, the Examiner(s) feel that continuation of a procedure will result in a health threat to the patient or in a clinically unacceptable treatment, the candidate will be instructed to terminate the procedure. Appropriate temporization and/or indication to the patient of the need for further treatment will be the responsibility of the candidate.
17. Candidate must have three Examiners check the following points in treatment:
 - a. pre-operative evaluation (Operative, Surgery, Periodontics)
 - b. after cavity preparation (Operative)
 - c. after base placement (Operative), one Examiner only
 - d. after condensation and carving of amalgam (Operative)
 - e. after extraction (Surgery)
 - f. after completion of scaling and root planning (Periodontics)
 - g. for each injection, one Examiner must be present

Operative Requirements

1. A class II amalgam with proper and traditional criteria.
2. Decay is to be through the enamel and invasive of the dentin.
3. There is to be a contacting adjacent tooth to the restoration.
4. There is to be an opposing tooth to the restoration.
5. Patient is to be presented with a mounted full mouth set of radiographs. Fourteen (14) periapical films plus bite-wing x-rays, all taken prior to the time of the examination will be the minimum acceptable. The full mouth radiographs must be current within the last six months. At the Examiner(s) discretion, pre-operative bite-wing or a periapical of the tooth to be treated may be required. A post-operative bite-wing radiograph of the treated tooth is required. A post-operative periapical radiograph may be required at the discretion of the Examiner(s).
6. Candidates are to supply their own hand pieces, instruments and supplies.

Surgical Requirements

1. An extraction of a maxillary or mandibular molar (multi-rooted, no fused root). A maximum of Class I mobility permitted. Surgical patient cannot be used for other procedures.
2. Tooth must have at least one contacting adjacent tooth.
3. At least 50% of the clinical crown must be present.
4. Full mouth or panoramic radiographs required, current within the last three years. A periapical radiograph of the tooth to be extracted current within the last six months required. At the discretion of the Examiner(s), the candidate may be required to take a pre-operative periapical of the tooth to be extracted. A post-operative radiograph of the extraction site is required.
5. Candidates are to provide surgery instruments.

Periodontal Requirements

1. Evidence of sub and supra-gingival calculus must be ascertained prior to approval to start. Sub-gingival calculus must be evident on radiograph and clinically.
2. Definitive scaling, sub and supra-gingival calculus removal, curettage, debridement, root planning on at least six (6) teeth, two of which are molars.
3. Full mouth set of radiographs required, current within the last three years. Periapical radiographs of the quadrant to be treated current within the last six months are required. Post-operative radiographs of the treated quadrant are required.
4. Candidates are to provide periodontal instruments.

Radiology Requirements

1. Radiographic requirements are included in each of the above three subject areas. If previous x-rays for patient are not available, it is the candidate's responsibility to provide radiographs to fit the above criteria.
2. Pre-op radiograph must have been completed when patient is presented.

Information on Written Examination

National Board scores must be current within the past two years to fulfill the written examination requirements. If more than two years, candidates are required to take the written examination (Computerized National Board Part II) with American Dental Association (ADA) prior to coming to the Virgin Islands to take the Clinical exam. Candidates **must** request transfer of their scores be forwarded to the Virgin Islands Board of Dental Examiners at 1303 Hospital Ground, Suite 10, St. Thomas, VI 00802.

The American Dental Association (ADA) address is: 211 East Chicago Avenue, Suite 600, Chicago, IL 60611-2637. Contact person: Mrs. Cora Lapuz-Adrovel at [REDACTED] or e-mail: [REDACTED]

If a candidate fulfills the written requirements but fails in the clinical, the Board will consider the written exam valid for six months during which the candidate may retake the clinical examination. Candidates wishing to re-take either the written or clinical must notify the Board in writing six weeks prior to the examination date.

A candidate that submits an application, which is approved, but fails to show for the examination must also notify the Board in writing six weeks prior to the exam date of his/her intentions to take the next scheduled examination.

APPLICANTS RECEIVE NO NATIONAL BOARD CREDIT FOR COMPUTERIZED NATIONAL BOARD PART II TAKEN FOR VIRGIN ISLANDS LICENSURE.

ONLY COMPLETED APPLICATIONS POSTMARKED SIX (6) WEEKS PRIOR TO THE EXAMINATION DATE (JUNE OR NOVEMBER) WILL BE CONSIDERED.