Application for t	he Month/Year:				
Application for F	Registration of Dental Assi	stant			
Applicant Name					
LAST		GIVEN NAMES			
OFFICE ADDRESS:	STREET	SUITE		СПҮ	
PROVINCE/STATE	POSTAL CODE	TEL	FAX	E-MAIL	
HOME ADDRESS:	STREET	SUITE		СІТУ	
PROVINCE/STATE	POSTAL CODE	TEL	FAX	E-MAIL	
DATE OF BIRTH MONTH/DAY/YEAR			PLACE OF BIR	тн	
GENDER: MAL	E FEMALE	FLUENT IN:	ENGLISH	FRENCH OTHER (S	SPECIFY)
	itizen or permanent resident of C			:	
If "yes", please provid	le a certified copy of your Canadi	an birth certificate, citize	nship card or proo	f of permanent residency	status.

Is the name on your application different from the one on your Diploma? YES NO

If "no", please provide details of your current citizenship and a certified copy of the authorization issued by Citizenship and

Immigration Canada which permits you to engage in the practice of dental assisting in Canada.

Please provide details: _______

Date of Name Change: ______ Location: ______

Please provide a certified copy of a legal document certifying name change, i.e. Marriage Certificate, Legal Name Change Decree, etc.

FOR OFFICE USE ONLY

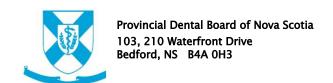
Date Received:	Registration No.:	Registration Date:

_			
PHOTO: Please paste a passport style photo taken within the past twelve months and sign in the space indicated.			
	SIGNATURE		
DENTAL ASSISTING EDUCATION			
NAME OF LOCATION	DIPLOMA	DATE STARTED	DATE COMPLETED
		mm/dd/yy	mm/dd/yy
		mm/dd/yy	mm/dd/yy
-	ead of the Program or his/her designate and reinstating, it is not necessary to forward this		your diploma certifying
If yes, please provide a certified copy.	ional Dental Assistant Examining Board of Ca		NO
Please provide NDAEB Certificate No Date of Issue: Enclose copy			
program of study, from a course or any cour misconduct or unprofessional behaviour irre behaviour on your academic transcript from	have you ever been found guilty of miscond se activity, required to withdraw, expelled or spective of whether there is currently a notat	penalized by a post-section of such misconduct c	ondary institution for

If "yes" to the above question, please provide full details including copies of any documents in your possession referable to the matter. Attach a separate record if there is insufficient space in the box below.



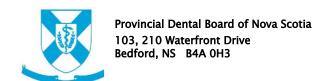
	APPLICATION FORM 2019		
PRACTICE INFORMATION			
Have you practiced or been previously registered/licensed to praccountry / province / state outside of Nova Scotia]?	tice dental assisting (or any health	profession) in any jurisdiction /	
 ☐ YES You are required to complete PART B of the ATTACHED CON ☐ NO	ISENT FOR RELEASE IF INFORMATION	FORM	
If "yes", check the form of registration/license you held and registered/licensed. Attach a separate list if required.	list all of the locations at which	you have practiced or where	
Country/Province or State/Region	REGISTERED/LICENSED		
Country (1104) The Co. State (1105)	From (M/D/Y)	To (M/D/Y)	
If you have practiced or been previously registered / licensed to practice of practice of practice of the practice of dental assisting or any health of any proceedings in that jurisdiction referable to your competen (incapacity)?	ificate of Standing. h profession in any other jurisdiction	, have you ever been the subject	
YES NO			
If "yes", please provide full details including copies of any docum record if there is insufficient space in the box below.	nents in your possession referable to	o the matter. Attach a separate	



Have you ever been refused registration/licensure in any jurisdiction?
☐ YES ☐ NO
Since completing dental assisting, have you practiced dental assisting in the preceding 5 year period from your date of application?
YES NO New Graduate - Not Applicable
HEALTH HISTORY
Do you currently suffer from any physical or mental condition or disorder which may impair your ability to practice dental assisting safely and competently or which, if left untreated, would impair your ability to practice dental assisting safely and competently?
YES YOU ARE REQUIRED TO COMPLETE "PART C" OF THE ATTACHED CONSENT FOR RELEASE OF INFORMATION FORM.
□ NO
If your answer to either of the above two questions is "yes", please provide full details including the names and addresses of all health-care practitioners who have treated you in respect of the condition/disorder as well as providing a separate release (Form B) so that we may obtain the information directly from them.
JUDICIAL PAST CONDUCT
Have you ever had a summary conviction or been found guilty of a criminal offence, either in Canada or in any other jurisdiction? This includes a finding of guilt under the Criminal Code of Canada, the Controlled Drugs and Substances Act (Canada) [formerly the Narcotic Control Act (Canada)] and the Food and Drugs Act (Canada) or any other offence where the penalty could have involved your being incarcerated.
YES YOU ARE REQUIRED TO COMPLETE "PART D" OF THE ATTACHED CONSENT FOR RELEASE OF INFORMATION FORM.
□ NO



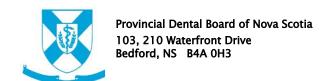
If the answer was "yes" to the question above, provide full details of the guilty finding and include copies of all relevant documents in your possession or control referable to the matter. Attach a separate summary if there is insufficient space below.
Please provide the Provincial Dental Board a Vulnerable Sector Check with your application form. Please provide two written character references from individuals who are non-family members and who have known you for the past four years.
DECLARATION
I solemnly declare that the contents of this application are true and complete to the best of my knowledge and belief. I understand and agree that if I make a false or misleading statement or representation in respect of my application or submit falsified documentation, I shall be deemed not to have satisfied the requirements for a Certificate of Registration. I further understand and agree that if a Certificate of Registration should be issued to me based upon a false or misleading statement, representation or documentation then the Certificate is subject to immediate revocation/cancellation.
Taken and declared before me in the District, Province, State of
thisday of, 20
Notary Public, Lawyer, Officer of an Embassy or Consulate
(Official seal, stamp, or business card must be provided.)
Signature of Applicant (APPLICATION VALID FOR 3 MONTHS FROM THE DATE OF SIGNING/ATTESTATION.)



PART A – RELEASE OF ACADEMIC INFORMATION COMPLETE IF APPLICABLE

I have made application with the Provincial Dental Board of Nova Scotia (Dental Board) for a Certificate of Registration in order to engage in the practice of dental assisting in Nova Scotia. The Dental Board may wish additional information in connection with my application and I have agreed to co-operate with the Dental Board to assist it in processing my application.

I therefore, hereby authoriz	e and direct the:		
Name of Undergraduate Ins	titution you attended :		_
Address			_
Country	Postal/Zip Code	Telephone No.	_
relating to any misconduct activity, any requirement the	, including academic miscor nat I withdraw from studies, sional behavior, irrespective	nduct, any suspension from a any expulsion or other penalt	mation in relation to any matters program of study or any course by by a post-secondary institution t notation of such misconduct on
	is consent and that I have ei	•	al Board that I should obtain lega ient opportunity to do so prior to
Date:			
Signature of Applicant		Signature of Witness	
Applicant (print name)		Witness (print name)	
Unless Required to Comp Confidential to :	lete any other Part of th	is Consent Form, return com	npleted Consent Form marked
		Registrar Provincial Dental Board 103, 210 Waterfront Di Bedford, NS B4A 0H3	

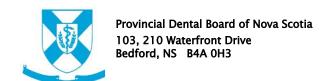


PART B – RELEASE OF INFORMATION FROM PRIOR REGULATORY BODIES COMPLETE IF APPLICABLE

OOM LETE II ALT LICABLE		
in order to engage in the practice of	dental assisting in Nova Scotia.	Scotia (Dental Board) for a Certificate of Registration a. The Dental Board may wish additional information e with the Dental Board to assist it in processing my
I therefore, hereby authorize and dir	ect the:	
Name of Regulatory Body (make add	ditional copy of this Consent For	orm if more than one Regulator)
Address		
Country	Postal/Zip Code	Telephone No.
application to the Dental Board, m therein, my continuing education	y history including complaints, standing, in addition to any providing a copy of any written	any and all information you may have respecting my as, investigations and any unresolved cases/matters information respecting my professional conducted in information in my file pertaining to these matters
	t and that I have either done so	advised by the Dental Board that I should obtain lega so or have had sufficient opportunity to do so prior to
Date:		
Signature of Applicant	Signature of	of Witness
Applicant (print name)	Witness (pr	print name)

Unless Required to Complete Part C or D of this Consent Form, return completed Consent Form marked Confidential to:

Registrar Provincial Dental Board of Nova Scotia 103, 210 Waterfront Drive Bedford, NS B4A 0H3

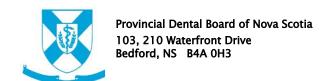


PART C – RELEASE OF HEALTH INFORMATION

COMPLETE IF APPLICABLE

Signature of Applicant	Signa	ature of Witness	
Date:			
	consent and that I have either	been advised by the Dental Board that done so or have had sufficient opportu	_
		directly should it find it necessary to s, and this shall be your full and final au	
Country	Postal/Zip Code	Telephone No.	
Address			
Name of Health Care Pract practitioner)	itioner(s) (make additional	copies of Consent Form if more th	an one health-care
the Dental Board at my exper		orize the following health-care practiti eports, records, and documents, includ treatment of me.	
	ental assisting in Nova Scotia ion and I have agreed to co-	of Nova Scotia for a Certificate of Reg a. The Dental Board may wish addit operate with the Dental Board to ass	ional information in
I have made application with			

Registrar Provincial Dental Board of Nova Scotia 103, 210 Waterfront Drive Bedford, NS B4A 0H3



PART D - RELEASE OF JUDICIAL INFORMATION

COMPLETE IF APPLICABLE

I have made application with the Provincial Dental Board of Nova Scotia for a Certificate of Registration in order to engage in the practice of dental assisting in Nova Scotia. The Dental Board may wish additional information in connection with my application and I have agreed to co-operate with the Dental Board to assist it in determining whether I am able to practice dental assisting safely. I therefore, hereby authorize and direct, instruct, and authorize the following judicial authority to release to the Provincial Dental Board of Nova Scotia at my expense any and all information, reports, records, and documents, including copies thereof in your possession or control, pertaining to my past judicial conduct. Name of Judicial Authority (make additional copies of this Consent Form if more than one is needed) **Address** Country Postal/ZipCode Telephone No Furthermore, I authorize you to speak to the Dental Board directly should it find it necessary to clarify or obtain any further information it may require in respect of these matters, and this shall be your full and final authority for doing so. It is further understood and acknowledged by me that I have been advised by the Dental Board that I should obtain legal advice prior to executing this consent and that I have either done so or have had sufficient opportunity to do so prior to executing this consent for release of information. **Signature of Applicant Signature of Witness**

Return completed Consent Form marked Confidential to:

Applicant (print name)

Registrar Provincial Dental Board of Nova Scotia 103, 210 Waterfront Drive Bedford, NS B4A 0H3

Witness (print name)