



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

## APPLICATION FORM 2023

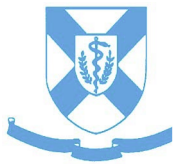
Application for the Month/Year: \_\_\_\_\_

### Application for Registration of Dental Assistant

<b>Applicant Name</b>					
<b>LAST</b>		<b>GIVEN NAMES</b>			
<b>OFFICE ADDRESS:</b>	<b>STREET</b>	<b>SUITE</b>	<b>CITY</b>		
<b>PROVINCE/STATE</b>	<b>POSTAL CODE</b>	<b>TEL</b>	<b>FAX</b>	<b>E-MAIL</b>	
<b>HOME ADDRESS:</b>	<b>STREET</b>	<b>SUITE</b>	<b>CITY</b>		
<b>PROVINCE/STATE</b>	<b>POSTAL CODE</b>	<b>TEL</b>	<b>FAX</b>	<b>E-MAIL</b>	
<b>DATE OF BIRTH</b>	<b>MONTH/DAY/YEAR</b>		<b>PLACE OF BIRTH</b>		
<b>GENDER:</b>	<input type="checkbox"/> MALE	<input type="checkbox"/> FEMALE	<b>FLUENT IN:</b>	<input type="checkbox"/> ENGLISH	<input type="checkbox"/> FRENCH <input type="checkbox"/> OTHER (SPECIFY)
Are you a Canadian citizen or permanent resident of Canada? <input type="checkbox"/> YES <input type="checkbox"/> NO    Citizenship: _____					
If "yes", please provide a certified copy of your Canadian birth certificate, citizenship card or proof of permanent residency status.					
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.					
Is the name on your application different from the one on your Diploma? <input type="checkbox"/> YES <input type="checkbox"/> NO					
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: \_\_\_\_\_



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### 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

Please provide an original letter from the Head of the Program or his/her designate and a certified photocopy of your diploma certifying your graduation in dental assisting. Note: If reinstating, it is not necessary to forward this documentation again.

### NDAEB CERTIFICATE

Do you have a certificate issued by the National Dental Assistant Examining Board of Canada? ☐ YES ☐ NO  
If yes, please provide a certified copy.

Please provide NDAEB Certificate No. \_\_\_\_\_ Date of Issue: \_\_\_\_\_  
Enclose copy

### CONDUCT DURING ACADEMIC STUDIES

While attending a post-secondary institution have you ever been found guilty of misconduct. Have you ever been suspended from a program of study, from a course or any course activity, required to withdraw, expelled or penalized by a post-secondary institution for misconduct or unprofessional behaviour irrespective of whether there is currently a notation of such misconduct or unprofessional behaviour on your academic transcript from the academic institution?

- ☐ YES You are required to complete PART A of the ATTACHED CONSENT FOR RELEASE IF INFORMATION FORM  
☐ NO

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.



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### PRACTICE INFORMATION

Have you practiced or been previously registered/licensed to practice dental assisting (or any health profession) in any jurisdiction / country / province / state outside of Nova Scotia?

- ☐ YES You are required to complete PART B of the ATTACHED CONSENT FOR RELEASE IF INFORMATION FORM  
☐ NO

If "yes", check the form of registration/license you held and list all of the locations at which you have practiced or where registered/licensed. Attach a separate list if required.

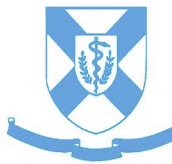
Country/Province or State/Region	REGISTERED/LICENSED	
	From (M/D/Y)	To (M/D/Y)

If you have practiced or been previously registered / licensed to practice dental assisting or any health profession in any jurisdiction / country / province / state outside of Nova Scotia complete our Certificate of Standing.

If you have engaged in the practice of dental assisting or any health profession in any other jurisdiction, have you ever been the subject of any proceedings in that jurisdiction referable to your competence (professional misconduct or incompetence) or fitness to practice (incapacity)?

- ☐ YES ☐ NO

If "yes", 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.

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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 health condition which may impair your ability to practice dental assisting and/or could negatively impact the safety of patients and/or staff?

☐ YES **YOU ARE REQUIRED TO COMPLETE "PART C" OF THE ATTACHED CONSENT FOR RELEASE OF INFORMATION FORM.**

☐ NO

Are you currently being treated for any physical or mental health condition which, if left untreated, may impair your ability to practice dental assisting competently and/or could negatively impact the safety of patients and/or staff?

☐ YES **YOU ARE REQUIRED TO COMPLETE "PART C" OF THE ATTACHED CONSENT FOR RELEASE OF INFORMATION FORM.**

☐ NO

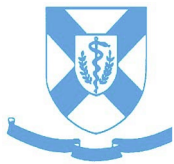
If your answer to either of the above two questions is "yes", please provide full details including the names and addresses of all health-care practitioners who have treated you in respect of the condition/disorder as well as providing a separate release (Form B) so that we may obtain the information 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



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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 province of \_\_\_\_\_

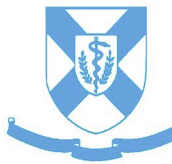
this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

\_\_\_\_\_  
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.)



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## APPLICATION FORM 2023

### 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 authorize and direct the:

Name of Undergraduate Institution you attended : \_\_\_\_\_

\_\_\_\_\_

Address

\_\_\_\_\_

Country

Postal/Zip Code

Telephone No.

to provide the Dental Board, at my expense, with full disclosure of any and all information in relation to any matters relating to any misconduct, including academic misconduct, any suspension from a program of study or any course activity, any requirement that I withdraw from studies, any expulsion or other penalty by a post-secondary institution for misconduct or unprofessional behavior, irrespective of whether there is a current notation of such misconduct or unprofessional behavior on my academic transcript.

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.

Date: \_\_\_\_\_

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

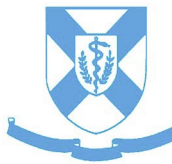
\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Applicant (print name)

\_\_\_\_\_  
Witness (print name)

Unless Required to Complete any other Part of this Consent Form, return completed Consent Form marked Confidential to :

Registrar  
Provincial Dental Board of Nova Scotia  
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### PART B – RELEASE OF INFORMATION FROM PRIOR REGULATORY BODIES

#### 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 authorize and direct the:

Name of Regulatory Body (make additional copy of this Consent Form if more than one Regulator)

Address

Country

Postal/Zip Code

Telephone No.

to provide the Dental Board, at my expense, with full disclosure of any and all information you may have respecting my application to the Dental Board, my history including complaints, investigations and any unresolved cases/matters therein, my continuing education standing, in addition to any information respecting my professional conduct, competence and capacity including providing a copy of any written information in my file pertaining to these matters and this shall be your full and final authority for so doing.

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.

Date: \_\_\_\_\_

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

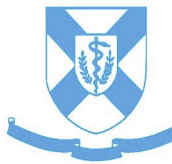
\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Applicant (print name)

\_\_\_\_\_  
Witness (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  
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### PART C – RELEASE OF HEALTH 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 health-care practitioner(s) to release to the Dental Board at my expense any and all information, reports, records, and documents, including copies thereof in your possession or control, pertaining to my health and your treatment of me.

\_\_\_\_\_  
Name of Health Care Practitioner(s) (make additional copies of Consent Form if more than one health-care practitioner)

\_\_\_\_\_  
Address

\_\_\_\_\_  
Country

\_\_\_\_\_  
Postal/Zip Code

\_\_\_\_\_  
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 health information.

Date: \_\_\_\_\_

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

\_\_\_\_\_  
Signature of Witness

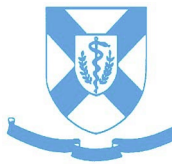
\_\_\_\_\_  
Applicant (print name)

\_\_\_\_\_  
Witness (print name)

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

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### 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.

**Date:** \_\_\_\_\_

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

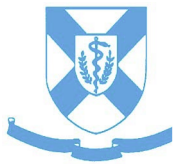
\_\_\_\_\_  
**Signature of Witness**

\_\_\_\_\_  
**Applicant (print name)**

\_\_\_\_\_  
**Witness (print name)**

**Return completed Consent Form marked Confidential to:**

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