Provincial Dental Board of Nova Scotia
102, 1559 Brunswick Street
Halifax, Nova Scotia
B3J 2G1

APPLICATION FORM 2015

Application for the Month/Year: _____

TYPE OF REGISTRATION

☐ GENERAL ☐ SPECIALTY _____ ☐ SPECIALIST LIMITED TO THEIR SPECIALTY

☐ STUDENT

Applicant Name		
LAST	GIVEN NAMES	

OFFICE ADDRESS:	STREET	SUITE	CITY	
PROVINCE/STATE	POSTAL CODE	TEL	FAX	E-MAIL

HOME ADDRESS:	STREET	SUITE	CITY	
PROVINCE/STATE	POSTAL CODE	TEL	FAX	E-MAIL

DATE OF BIRTH / / MONTH/DAY/YEAR PLACE OF BIRTH

GENDER: ☐ MALE ☐ FEMALE FLUENT IN: ☐ ENGLISH ☐ FRENCH ☐ OTHER (SPECIFY)

Are you a Canadian citizen or permanent resident of Canada? ☐ YES ☐ 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 dentistry in Canada.

Is the name on your application different from the one on your Degree? ☐ YES ☐ 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 EDUCATION

NAME OF UNIVERSITY/LOCATION	DIPLOMA/DEGREE	DATE STARTED	DATE COMPLETED
		mm/dd/yy	mm/dd/yy
		mm/dd/yy	mm/dd/yy

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

NDEB CERTIFICATE

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

Please provide NDEB Certificate No. _____ Date of Issue: _____

POST GRAD EDUCATION (INTERNSHIP OR SPECIALTY PROGRAM)

NAME OF UNIVERSITY/LOCATION	DIPLOMA/DEGREE	DATE STARTED	DATE COMPLETED
		mm/dd/yy	mm/dd/yy
		mm/dd/yy	mm/dd/yy

Please provide an original letter from the Dean or Director of postgraduate studies or his/her designate and a certified photocopy of your diploma certifying your graduation in your postgraduate dental program.

Royal College of Dentists of Canada National Dental Specialty Examination (NDSE): ☐ YES ☐ NO

Date: _____
If "yes", please have the RCDC forward a letter to the Provincial Dental Board of Nova Scotia verifying your successful completion.

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CONDUCT DURING ACADEMIC STUDIES

While attending a post-secondary institution (undergraduate and post-graduate), have allegations of misconduct, including academic misconduct ever been made against you or 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 ☐ NO

Irrespective of whether you answered "Yes" or "No" to this question, YOU ARE REQUIRED TO COMPLETE "PART A" OF THE ATTACHED CONSENT FOR RELEASE OF INFORMATION FORM.

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.

PRACTICE INFORMATION

Have you practiced or been previously registered/licensed to practice dentistry (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.

☐ (i) a General Licence from _____ (M/D/Y) to _____ (current or M/D/Y)..
☐ (ii) a Specialty Licence in _____ (specify specialty) from _____ to _____(current or M/D/Y).
☐ (iii) a Student License from _____ to _____(current or M/D/Y).
☐ (iv) a Limited Specialty License from _____ to _____(current or M/D/Y) .

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

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If you have practiced or been previously registered / licensed to practice dentistry 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 dentistry 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.

Have you ever been refused registration/licensure in any jurisdiction?

☐ YES ☐ NO

Since completing either an undergraduate dental program or specialty program or having been assessed and obtained a Certificate of Completion from an approved Canadian University, have you practiced a minimum of 450 hours within the preceding 3 year period from your date of application?

☐ 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.

HEALTH HISTORY

Do you currently suffer from any physical or mental condition or disorder which may impair your ability to practice dentistry safely and competently or which, if left untreated, would impair your ability to practice dentistry safely and competently?

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

☐ NO

Have you at any time during the previous ten years suffered from a physical or mental condition or disorder which has impaired your ability to practice dentistry safely and competently or which, if left untreated, would have impaired your ability to practice dentistry 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.

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Please provide the Provincial Dental Board a Criminal Record Check and 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

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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PART A – RELEASE OF ACADEMIC INFORMATION

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 dentistry 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 irrevocably authorize and direct the:

Name of Undergraduate Institution you attended :_____

_____
Address

_____
Country Postal/Zip Code Telephone No.

Name of Graduate 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 allegations of misconduct, including academic misconduct ever made against me, 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
102, 1559 Brunswick Street
Halifax, NS B3J 2G1

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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 dentistry 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 irrevocably 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, final and irrevocable 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
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PART C – RELEASE OF HEALTH INFORMATION

Complete if Applicable (Complete only if answer to Health History is "Yes")

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 dentistry 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 dentistry safely.

I therefore, hereby irrevocably 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, final and irrevocable 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:

Registrar
Provincial Dental Board of Nova Scotia
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Halifax, NS B3J 2G1

PART D – RELEASE OF JUDICIAL INFORMATION

Complete if Applicable (Complete only if answer to past judicial conduct is "Yes")

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 dentistry 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 dentistry safely.

I therefore, hereby irrevocably 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, final and irrevocable 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:

Registrar
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