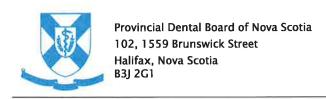
Application for	the Month/Year:				
TYPE OF REGIST	RATION				
GENERAL STUDENT	SPECIALTY	🗅	SPECIALIST LIMITE	ED TO THEIR SPECI	IALTY
Applicant Name					
LAST		GIVEN NAMES			
OFFICE ADDRESS:	STREET	SUITE		CITY	
PROVINCE/STATE	POSTAL CODE	TEL	FAX	E-MAIL	
			.,		
HOME ADDRESS:	STREET	SUITE		CITY	
PROVINCE/STATE	POSTAL CODE	TEL	FAX	E-MAIL	
DATE OF BIRTH	/ / MONTH/DAY/YEAR		PLACE OF BIRT	TH	
GENDER: MA	ALE FEMALE	FLUENT IN:	ENGLISH L	FRENCH OTHE	er (Specify)
Are you a Canadian	citizen or permanent resident of Canada	a? YES 📮	NO Citizenship:		
If "ves", please prov	ide a certified copy of your Canadian bir	th certificate, citiz	enship card or proof	of permanent reside	ncy status.
	vide details of your current citizenship a which permits you to engage in the pra		* *	ation issued by Citi	zensnip and
Is the name on your	application different from the one on y	our Degree?	YES	NO	
Please provide detai	lls:				
Date of Name Chan	qe:	Loca	ition:		
	rtified copy of a legal document certify				ange Decree,
FOR OFFICE US	E ONLY				
Date Received:	Registratio	n No :	Dog	istration Date:	

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
NDEB CERTIFICATE Do you have a certificate issued by the Nat If yes, please provide a certified copy.	*	□ YES □ NO	
Please provide NDEB Certificate No	Date of Issue:	************	
POST GRAD EDUCATION (INTERNSHIP C	DR SPECIALTY PROGRAM)		
NAME OF UNIVERSITY/LOCATION	DIPLOMA/DEGREE	DATE STARTED	DATE COMPLETED
		mm/dd/yy	mm/dd/yy
		mm/dd/in/	mm/dd/se/
Please provide an original letter from the E your diploma certifying your graduation in y	Dean or Director of postgraduate studies or our postgraduate dental program.	mm/dd/yy his/her designate and a	mm/dd/yy
Royal College of Dentists of Canada Nationa	l Dental Specialty Examination (NDSE): 🔲 Y	res 🔲 no	
Date:	er to the Provincial Dental Board of Nova Scot	tia verifying your success	ful completion.



CONDUCT DURING ACADEMIC STUDIES

While attending a post-secondary institution (undergraduate and post misconduct ever been made against you or have you ever been susp activity, required to withdraw, expelled or penalized by a post-secon irrespective of whether there is currently a notation of such miscondithe academic institution?	ended from a program of study, fron dary institution for misconduct or ur	n a course or any course aprofessional behaviour
☐ YES ☐ NO		
Irrespective of whether you answered "Yes" or "No" to this question, CONSENT FOR RELEASE OF INFORMATION FORM.	YOU ARE REQUIRED TO COMPLETE "P	ART A" OF THE ATTACHED
If "yes" to the above question, please provide full details including of Attach a separate record if there is insufficient space in the box below		session referable to the matter.
PRACTICE INFORMATION		
Have you practiced or been previously registered/licensed to practic province / state outside of Nova Scotia]?	ce dentistry (or any health profession	n) in any jurisdiction / country /
YES You are required to complete PART B of the ATTACHED CONS	SENT 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
(i) a General Licence from (M/D/Y) to	(current or M/D/Y)	
(ii) a Specialty Licence in(specify special	<u>llty)</u> from(c	urrent or M/D/Y).
iii) a Student License from to(co	urrent or M/D/Y).	
(iv) a Limited Specialty License from to	(current or M/D/Y) ,	
	REGISTERED	/LICENSED
Country/Province or State/Region	From (M/D/Y)	To (M/D/Y)



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

APPLICATION FORM 2015

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



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

APPLICATION FORM 2015

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.



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

APPLICATION FORM 2015

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 o	declared before me in	the District, Province, State of	
this	day of		
	Office of	- Full Consults	
Notary Publ	lic, Lawyer, Officer of	an Embassy or Consulate	
(Official sea	d, stamp, or business	card must be provided.)	
Signature o	f Applicant		

(APPLICATION VALID FOR 3 MONTHS FROM THE DATE OF SIGNING/ATTESTATION.)



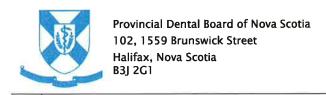
Confidential to:

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

APPLICATION FORM 2015

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 Telephone No. Country Postal/Zip Code 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. Signature of Witness Signature of Applicant Witness (print name) Applicant (print name) Unless Required to Complete any other Part of this Consent Form, return completed Consent Form marked

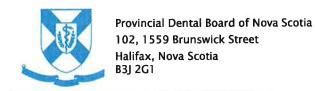


PART B - RELEASE OF INFORMATION FROM PRIOR REGULATORY BODIES

COMPLETE IF APPLICABLE

COMPLETE IF APPLICABLE			
I have made application with the Proin order to engage in the practice of connection with my application and application.	of dentistry in Nova Scotia. Th	he Dental Board may wish addition	al information in
I therefore, hereby irrevocably autho	rize and direct the:		
Name of Regulatory Body (make add	ditional copy of this Consent F	orm if more than one Regulator)	
Address			
Country	Postal/Zip Code	Telephone No.	
to provide the Dental Board, at my e application to the Dental Board, m therein, my continuing education competence and capacity including a and this shall be your full, final and ir	y history including complaint standing, in addition to any providing a copy of any writte	es, investigations and any unresolver information respecting my profer information in my file pertaining	ed cases/matters essional conduct,
It is further understood and acknowle advice prior to executing this consen executing this consent for release of	t and that I have either done s		
Date:			
Signature of Applicant	Signature of	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:



Applicant (print name)

APPLICATION FORM 2015

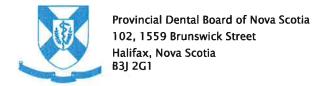
PART C – RELEASE OF HEALTH INFORMATION

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 Telephone No. Country Postal/Zip Code 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. Signature of Applicant Signature of Witness

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

Witness (print name)



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		
·		ard directly should it find it necessary to clarify or obta tters, and this shall be your full, final and irrevocable au		
advice prior to executing		ave been advised by the Dental Board that I should obtai er done so or have had sufficient opportunity to do so p	_	
Date:				
Date: Signature of Applicant	s	ignature of Witness		
n=		ignature of Witness Vitness (print name)		