Education & Research Satellite Rotation Application Requirements

This application is for dentists who are applying for registration on the Education & Research register for **Satellite Clinic** coverage with the University of Alberta.

All application information and supporting documents must be supplied electronically to Registration@cdsab.ca. **This includes notarized or certified documents.**

Transcripts, Certificates of Standing, and Letters of Good Standing from other jurisdictions must be sent by email, directly from the source, to Registration@cdsab.ca. It is the responsibility of the applicant to ensure all documents are supplied.

Documents are reviewed and processed in the order in which they are received.

The Registrations team will provide email confirmation of receipt upon review and the start of the application. Any additional information required will be outlined by email to the applicant.

APPLICATION PREPARATION

The following information must be emailed to the CDSA directly from the source:

☐ A letter from the Dean of the Faculty of Medicine and Dentistry confirming the appointment(s) and outlining of duties.

☐ Certificates of Standing (if applicable).
- If currently **or** previously registered in any Canadian province.
- Certificates of Standing are valid for 8 weeks from the date they are issued.
- The applicant is responsible for ensuring this information is current.
- The Certificate of Standing must be emailed directly to the CDSA from each regulatory body in which the applicant is/was registered. Certificates of Standing sent by the applicant will not be accepted.

☐ Letter of Good Standing (if applicable)
- If currently **or** previously registered in the Yukon, Northwest Territories, Nunavut, the U.S.A. or Internationally.
- This is to be included from any other dental professions currently or previously registered with (i.e, Hygienist, Assistant, etc.).
- The letter must be emailed directly to the CDSA from each regulatory body in which the applicant is/was registered. Letters of Good Standing sent by the applicant will not be accepted.
- Letters of Good Standing are valid for 8 weeks from the date they are issued.
- The applicant is responsible for ensuring this information is current.

The following information must be supplied to the CDSA by the applicant. All documents must be clear and readable.

- □ Completed application and payment of $500 Canadian.
- □ Notarized or Certified copy of government issued photo identification.
  - Passport, citizenship card, or proof of permanent residency status.
  - Or a certified copy of the authorization issued by Citizenship and Immigration Canada of a person lawfully permitted to work in Canada.

- □ Notarized or Certified copy of dental degree(s) or diploma(s) earned.
  - Testimurs are not accepted.

- □ Criminal Record Check and Vulnerable Sector Check from within the last 12 months.
- □ Criminal Record Check and Vulnerable Sector Check Consent form.
- □ Proof of current HCP/CPR including AED or equivalent certification within the last 6 months.
- □ Consent for Release of Information form(s) for each jurisdiction in which the applicant is/was registered.

College of Dental Surgeons of Alberta

Education & Research Instructor Application

Application date:

CONTACT INFORMATION

The CDSA is governed by the *Health Professions Act* (the "HPA").
CDSA bylaws require a valid email address specific to the applicant for the purpose of receiving communications from the college.

Name: (First Name) (middle name(s) or initial) (surname)

Preferred display name: _____

Is this name different from the one on your Degree(s)/Certificate(s): ____(yes/no)_____
If yes, the name displayed is: _____

☐ If yes, a copy of legal documents of name change is attached.
(i.e. marriage certificate or legal name change decree)

Home Address:

_____

_____
(City) Province/State (Postal/ZIP Code)

(_____)_____ (_____)_____
(Home Phone Number) (Cell Phone Number)

_____
(Email Address)

Work Address: (if available) ❑ I do not currently have a practice address.

_____

_____
(City) Province/State (Postal/ZIP Code)

(_____)_____ (_____)_____
(Home Phone Number) (Cell Phone Number)

_____
(Email Address)

I wish to receive mail from CDSA

☐ At my practice address
☐ At my home address

PERSONAL INFORMATION

Place of Birth: _____ Date of Birth: ____/____/____
Month Day Year

Gender identity: ❑ Male ❑ Female ❑ non-binary ❑ Other: _____

Additional language(s) spoken
As a courtesy to the public, this information will be provided within your listing on the online Registrant Lookup.

_____ _____
_____ _____

SATELLITE CLINIC INFORMATION

Location: _____

Start date: _____

A letter of confirmation has been requested from the Dean at the University of Alberta and will be supplied directly to the CDSA.

Yes No

PRACTICE INFORMATION

1. Prior Registration in Alberta

Have you previously been registered with the CDSA or former Alberta Dental Association and College (ADA&C) ❑ Yes ❑ No

If yes, what was the permit number _____ Last year of registration _____

2. Other jurisdictions

Do you hold active dental healthcare registration in any of the following jurisdiction(s):
(Dentist, Hygiene, Assistant, etc)

- ☐ Canada
- ☐ United States of America
- ☐ Internationally
- ☐ Not applicable

If yes, indicate jurisdictions below.

Jurisdiction (Province/State/Country)	Registered/Licensed/Certified From: M/D/Y	To: M/D/Y

- ☐ A Consent for Release of Information form is attached for each jurisdiction noted above.
- ☐ A Certificate of Standing has been requested from all Canadian jurisdictions I am currently active within as noted above.
- ☐ A Letter of Good Standing has been requested from all American and International jurisdictions I am currently active within as noted above.

Were you <u>previously</u> registered/licensed as a dental healthcare provider in any of the following jurisdictions? *(Dentist, Hygiene, Assistant, etc)*

- ☐ Canada
- ☐ United States of America
- ☐ Internationally
- ☐ Not applicable

If yes, indicate jurisdictions below.

Jurisdiction (Province/State/Country)	Registered/Licensed/Certified From: M/D/Y	To: M/D/Y

- ☐ A Certificate of Standing has been requested from all Canadian jurisdictions as noted above.
- ☐ A Letter of Good Standing has been requested from all American and International jurisdictions as noted above.
- ☐ I acknowledge that a Consent for Release of Information form will be supplied for each jurisdiction in which I am actively registered within noted above.

3. In-activity from Dentistry

Has there been a period during which you did not engage in the practice of dentistry on a continuous and regular basis? Yes No

If yes, indicate below.

Years(s)	Details	Location

4. Any Additional information

If there is any additional information that would be beneficial to the application, please indicate below.

CONDUCT INFORMATION

- □ A Criminal Record Check and Vulnerable Sector Check from within the last 12 months is attached.
- □ Consent for the release of information for the Criminal Record and Vulnerable Sector Check is attached.

All the following questions **must** be answered. A **written explanation** must be provided for all affirmative answers. The information provided is kept confidential to the CDSA. If you are unclear or unsure about how to respond to any of these questions, please contact staff for clarification.

1.	Have you ever 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 offences where the penalty could have involved you being incarcerated?	**Yes** **No**
2.	Have you ever had any allegations of misconduct, including academic misconduct made against you or have you ever been suspended, required to withdraw, expelled, or penalized for misconduct from any or all components of any academic program? If yes, provide details of the allegations, suspensions, expulsion, or penalty imposed upon you.	**Yes** **No**
3.	Has there ever been a judgment in a civil action against you in relation to your practice?	**Yes** **No**
4.	Has your entitlement to practice dentistry ever been limited, restricted or subject to conditions in any jurisdiction at any time?	**Yes** **No**
5.	Have you ever been refused registration in any jurisdiction?	**Yes** **No**
6.	Have you ever voluntarily surrendered your registration/license/certificate?	**Yes** **No**
7.	Have you ever practiced as a dentist without being registered/licensed/certified?	**Yes** **No**
8.	At the present time, are there any investigations, reviews or proceedings taking place in any jurisdiction that could result in sanctions against you including conditions of your practice permit, or the suspension or cancellation of your authorization to practice dentistry?	**Yes** **No**
9.	Do you have a mental or physical condition that could affect your ability to safely practice dentistry? Examples: mental or physical ailment, psychiatric disorder, addiction, blood borne pathogens	**Yes** **No**

10.	Have/do you held/hold any other professional designation? If yes, provide a copy of the certificate. If yes, a Letter of Good Standing from all jurisdictions currently or previously registered is required.	**Yes** **No**

PRIVACY AND SECURITY

The College of Dental Surgeons of Alberta (CDSA) collects the above information for the purposes of registration within the province of Alberta. The information is only used or shared as regulated by the *Health Professions Act (HPA)* and *Personal Information Protection Act (PIPA)*. The CDSA retains this information indefinitely in secured files. Business contact information may be shared with other organizations.

Some of the information CDSA collects must be publicly accessible pursuant to the HPA.

DECLARATION

I hereby make an application for registration as a Dentist under the Laws of the Province of Alberta under Part 2 of the *Health Professions Act*.

I understand that the fee for the evaluation of my qualifications is $500.00. A credit card payment authorization form for this amount is included.

The College of Dental Surgeons requires a minimum of $2 million in professional liability insurance. This insurance will be included in the annual practice permit fee.

I understand that I cannot practice dentistry in the Province of Alberta until I am approved and have completed the CDSA Registration process.

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 to my application, I shall be deemed not to have satisfied the requirements for a Practice Permit. I further understand and agree that if a Practice Permit should be issued to me based upon a false or misleading statement or representation, that Permit is subject to immediate cancellation.

_____

Signature of Applicant

Dated this _____ day of _____, 20____.

This form can be either printed and signed or digitally verified signature or DocuSign.

CDSA
College of Dental Surgeons of Alberta

EDUCATION AND RESEARCH REGISTER
(Satellite Rotation)

One Time Credit Card Payment Authorization Form

Please complete and sign this form to authorize the College of Dental Surgeons to make a one-time charge to the credit card listed below.

AUTHORIZATION

I, _____ authorizethe College of Dental Surgeons of Alberta to charge the credit card account indicated below for the amount of $100.00 per rotation for the purpose of the Education and Research Satellite permit fee.

APPLICANT CONTACT INFORMATION

Address _____ Phone Number _____

_____

City and Province _____ Postal Code _____

Email _____

Card Type: ❑ VISA ❑ Debit VISA ❑ MasterCard ❑ American Express

Cardholder Name (as appears on front of card): _____

Card Number: _____

Expiration Date: _____ CVV Number: _____

SIGNATURE _____ **DATE** _____

The College of Dental Surgeons of Alberta is hereby authorized to charge the credit card indicated in this authorization form according to the terms outlined above. This payment authorization is for the application fee indicated above, and is valid for one time use only. I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit card company, so long as the transaction corresponds to the terms indicated in this form.

Accounting records are kept in order to invoice and process the appropriate fees for applications. Information collected is used for the purpose noted above and then destroyed by confidential shredding.

Consent for Release of Information

Please complete this form and return it to:
College of Dental Surgeons of Alberta
Attention: Registration Department
Suite 402, 7609 – 109 Street
Edmonton, Alberta T6G 1C3

I, Dr. Name of Applicant
(FIRST NAME / LAST NAME)

have made application with the College of Dental Surgeons of Alberta for a Certificate of
(RECEIVING JURISDICTION)
Registration/License in order to engage in the practice of dentistry in Alberta.

The College of Dental Surgeons of Alberta, as part of its registration/licensure process, requires that it's Certificate of Standing form be completed by every jurisdiction in which I was licensed/registered and/or engaged in the practice of dentistry or applied for registration. As most jurisdictions require my consent to release the requested information, I am hereby signing my permission to and irrevocably authorize and direct the

Name of Regulatory Authority
(ORIGINATING JURISDICTION)

to provide, at my expense, any information requested by the College of Dental Surgeons of Alberta. I understand and accept that this means providing full disclosure of any and all information that was obtained while performing this adjudicative function. This can include but is not limited to, amongst other matters, information whether deemed public or non-public, undertakings or agreements, verbal or written between me and the

Name of Regulatory Authority
(ORIGINATING JURISDICTION)

about complaints, investigations, inspections, professional conduct, competence, fitness and capacity, past and present, and any and all applications to register to practice dentistry including providing a copy of any written information in my

Name of Regulatory Authority
(ORIGINATING JURISDICTION)

file pertaining to these matters and this shall be your full final and irrevocable authority for so doing.

Moreover, the College of Dental Surgeons of Alberta may wish further information or clarification respecting information it receives from the

Name of Regulatory Authority _____
(ORIGINATING JURISDICTION)

in connection with my application and I hereby further authorize the

Name of Regulatory Authority _____
(ORIGINATING JURISDICTION)

to assist and co-operate with the College of Dental Surgeons of Alberta in providing any other/ additional information it might request or that the

Name of Regulatory Authority _____
(ORIGINATING JURISDICTION)

deems to be relevant to my application in Alberta.

It is understood and acknowledged by me that I have been advised by the College of Dental Surgeons of Alberta that I might wish to 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. I am signing this document of my own free will, voluntarily and without coercion, having read it and having understood it.

I have duly executed this release form this _____ day of _____, 20____.

_____
Printed Name of Applicant

_____
Signature of Applicant

College of Dental Surgeons of Alberta

Consent to Request and Release of
Vulnerable Sector and Criminal Record Search
(To be provided to the CDSA)

Legal Name:_____
(First Name) *(Middle Name(s))* *(Last Name)*

Below are any former or other names I have used or are currently using:

1. _____
(First Name) *(Middle Name)* *(Last Name)*
2. _____
(First Name) *(Middle Name)* *(Last Name)*

I consent to a member of a police force or other authorized body to conduct a vulnerable sector criminal record search based on the above represented names and to provide the results. This search and results are necessary to apply to be registered as a dentist in Alberta by the College of Dental Surgeons of Alberta.

I understand that this means I am consenting in writing to a member of a police force or other authorized body to verify whether I am the subject of a notation made in accordance with section 6.3(2) of the *Criminal Records Act* (Canada).

Section 6.3(2) of the *Criminal Records Act* (Canada) outlines:

> The Commissioner shall make, in the automated criminal conviction records retrieval system maintained by the Royal Canadian Mounted Police, a notation enabling a member of a police force or other authorized body to determine whether there is a record of an individual's conviction for an offence listed in Schedule 2 in response of which a record of suspension has been ordered.

I understand that the College of Dental Surgeons of Alberta requires a criminal record check, that includes a vulnerable sector check, as part of my application to be registered as a dentist in Alberta. I further understand that the College of Dental Surgeons of Alberta will review and use the results of the criminal record check and the vulnerable sector check to determine if I meet the requirements of registration. The details of the criminal record check and the vulnerable sector check may result in my application for registration being refused. If my application is refused, I understand that I will be notified in writing with reasons for the application refusal and appeal process.

I understand that it is my decision to provide the results of the searches to the College of Dental Surgeons of Alberta. If I do not provide the results, my application will be incomplete, and I will not be registered in Alberta.

By signing this consent form below, I confirm that I have accurately and truthfully represented my name and names, if applicable, and understand the content, meaning and effect of this consent. I understand and agree that if I make a false or misleading statement or representation with respect to my application, I will be deemed to have not satisfied the requirements to register as a dentist in Alberta. I also understand and agree that if a Practice Permit Certificate is issued based on false or misleading information that I provided, the Practice Permit Certificate will be immediately cancelled.

_____ _____
Signature of Applicant Date