



Royal College of Dental Surgeons of Ontario

Ensuring Continued Trust

6 Crescent Road, Toronto, ON Canada M4W 1T1
T: 416.961.6555 F: 416.961.5814 Toll Free: 1.800.565.4591 www.rcdso.org

Application Form

Application for the Month/Year: _____

TYPE OF REGISTRATION Note: A separate application form is required for each type of registration.

- GENERAL, SPECIALTY, ACADEMIC, GRADUATE STUDENT, EDUCATION, POST-SPECIALTY TRAINING, ACADEMIC VISITOR, REINSTATEMENT

PERSONAL

APPLICANT NAME LAST NAME GIVEN NAMES
OFFICE ADDRESS STREET SUITE CITY
PROVINCE/STATE POSTAL CODE TEL FAX
E-MAIL

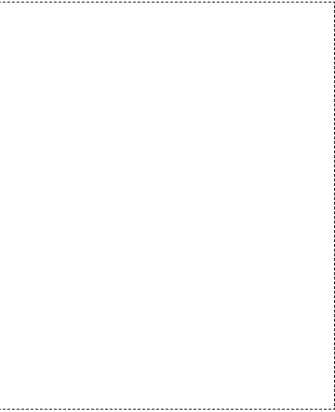
HOME ADDRESS STREET SUITE CITY
PROVINCE/STATE POSTAL CODE TEL FAX
E-MAIL

DATE OF BIRTH MONTH / DAY / YEAR PLACE OF BIRTH

GENDER MALE FEMALE FLUENT IN ENGLISH FRENCH

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 you are applying for 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, e.g. Marriage Certificate, Legal Name Change Decree, etc.

PASSPORT	PHOTO: Please paste a passport-sized photo taken within the past twelve months and sign in the space indicated.		
		_____ SIGNATURE	

DENTAL EDUCATION	NOTE: This section should include your original degree information and any subsequent degree obtained by other means, for example, a Qualifying/Degree Completion/Advanced Standing program.			
	NAME OF UNIVERSITY/LOCATION	DIPLOMA/DEGREE	DATE STARTED mm/dd/yyyy	DATE COMPLETED mm/dd/yyyy
			/ /	/ /
			/ /	/ /
Please provide an original letter from the Dean or his/her designate and a certified true copy of your original 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? <input type="checkbox"/> YES <input type="checkbox"/> NO If "yes", please provide a certified true copy of the original. If "no", are you applying using Labour Mobility legislation? <input type="checkbox"/> YES <input type="checkbox"/> NO Has there been a period of three years or more since you obtained your NDEB certificate during which you did not engage in the practice of dentistry on a continuous and regular basis either in Canada or the United States? <input type="checkbox"/> YES <input type="checkbox"/> NO
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POST GRADUATE EDUCATION (INTERNSHIP, SPECIALTY PROGRAM, GENERAL PRACTICE RESIDENCY, AEGD)	NAME OF UNIVERSITY/LOCATION	DIPLOMA/DEGREE	DATE STARTED mm/dd/yyyy	DATE COMPLETED mm/dd/yyyy
			/ /	/ /
			/ /	/ /
	Please provide an original letter from the Dean or Director of postgraduate studies or his/her designate and a certified true copy of your original diploma certifying your graduation in your postgraduate dental program. Royal College of Dentists of Canada Specialty Examination: <input type="checkbox"/> YES <input type="checkbox"/> NO Date: _____ If "yes", please have the RCDC forward a letter to the College verifying your successful completion. Since completing either an accredited specialty program (Canada or the United States) or having been assessed and obtaining a Certificate of Completion from an approved Canadian University, has there been a period of three years or more during which you did not engage in the specialty practice of dentistry on a continuous and regular basis either in Canada or the United States? <input type="checkbox"/> YES <input type="checkbox"/> NO			

JURISPRUDENCE & ETHICS COURSE	Have you taken the College's Jurisprudence and Ethics Course or completed our website version? <input type="checkbox"/> YES <input type="checkbox"/> NO Location and Date: _____
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PRACTICE INFORMATION

Have you practised or been previously registered/licensed to practise dentistry in any jurisdiction / country / province / state outside of Ontario? YES (FILL OUT ATTACHED RELEASE FORM) NO

If "yes", check the form of registration/licence you held and list all of the jurisdictions in which you practiced or were registered/licensed. Attach a separate list if required.

- (i) a General Certificate/Licence from _____ (M/D/Y) to _____ (current or M/D/Y).
- (ii) a Specialty Certificate/Licence in _____ (specify specialty) from _____ to _____ (current or M/D/Y).
- (iii) an Education Certificate/Licence (Residency/Internship) from _____ to _____ (current or M/D/Y).
- (iv) a Graduate Certificate/Licence (Student) from _____ to _____ (current or M/D/Y).
- (v) an Academic Certificate/Licence (Professor) from _____ to _____ (current or M/D/Y).
- (vi) other: _____ from _____ (M/D/Y) to _____ (current or M/D/Y).

COUNTRY/PROVINCE OR STATE/REGION	TYPE OF LICENCE (E.G. GENERAL, SPECIALTY)	REGISTERED/LICENSED	
		FROM (M/D/Y)	TO (M/D/Y)
		/ /	/ /
		/ /	/ /
		/ /	/ /

Have you practised or been registered/licensed to practise any health profession (e.g. hygienist, nurse, physician, optometrist, pharmacist, etc.) in any jurisdiction / country / province / state including Ontario? YES NO

If you have practised or been previously registered/licensed to practise dentistry (or any health profession) in any jurisdiction / country / province / state then you must have the governing body of the jurisdiction in which you were practicing or registered/licensed (even if you did not practice) complete our Certificate of Standing form. Please complete Form A so that we may obtain additional information from that governing body should we determine it appropriate to do so.

If you have engaged in the practise 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 practise (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

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 practise dentistry safely and competently or which, if left untreated, would impair your ability to practise dentistry safely and competently?

YES (FILL OUT FORM B) 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 practise dentistry safely and competently or which, if left untreated, would have impaired your ability to practise dentistry safely and competently?

YES (FILL OUT FORM B) 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 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.

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.)

FORM A

CONSENT FOR RELEASE OF INFORMATION

(Complete only if answer to Practice Information is "yes".)

I have made application with the Royal College of Dental Surgeons of Ontario (College) for a Certificate of Registration in order to engage in the practice of dentistry in Ontario.

The College may wish additional information in connection with my application and I have agreed to co-operate with the College to assist it in processing my application.

I, therefore, hereby irrevocably authorize and direct the:

NAME OF REGULATORY BODY (Make additional copies of Form A if more than one Regulator.)

ADDRESS

COUNTRY

POSTAL CODE

TELEPHONE NO.

to provide the Royal College of Dental Surgeons of Ontario, at my expense, with full disclosure of any and all information you may have respecting my application to you, 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 College 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

APPLICANT-PRINT NAME

WITNESS-PRINT NAME

DATE

Return completed form marked **Confidential** to: Manager, Registration, Royal College of Dental Surgeons of Ontario
6 Crescent Road, Toronto ON M4W 1T1 Telephone: 416.961.6555

FORM B

CONSENT FOR RELEASE OF HEALTH INFORMATION

(Complete only if answer to Health History is "yes".)

I have made application with the Royal College of Dental Surgeons of Ontario (College) for a Certificate of Registration in order to engage in the practice of dentistry in Ontario.

The College may wish additional information in connection with my application and I have agreed to co-operate with the College to assist it in determining whether I am able to practise dentistry safely.

I, therefore, hereby irrevocably direct, instruct, and authorize the following health-care practitioner(s) to release to the Royal College of Dental Surgeons of Ontario 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 Form B if more than one health-care practitioner.)

ADDRESS

COUNTRY

POSTAL CODE

TELEPHONE NO.

Furthermore, I authorize you to speak to the College 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 so doing.

It is further understood and acknowledged by me that I have been advised by the College 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

APPLICANT - PRINT NAME

WITNESS - PRINT NAME

DATE

Return completed form marked **Confidential** to: Manager, Registration, Royal College of Dental Surgeons of Ontario
6 Crescent Road, Toronto ON M4W 1T1 Telephone: 416.961.6555

FORM A

CONSENT FOR RELEASE OF INFORMATION

(Complete only if answer to Practice Information is "yes".)

[Empty rectangular box for Form A content]

FORM B

CONSENT FOR RELEASE OF HEALTH INFORMATION

(Complete only if answer to Health History is "yes".)

[Empty rectangular box for Form B content]