

**CDSBC**College of Dental Surgeons  
of British Columbia500 – 1765 West 8th Avenue  
Vancouver BC Canada V6J 5C6  
[www.cdsbc.org](http://www.cdsbc.org)Phone 604 736 3621  
Toll Free 1 800 663 9169  
Fax 604 734 9448**Dentist  
Application for Transfer from  
Non-practising to Practising Registration**

|                             |   |
|-----------------------------|---|
| <b>Surname</b>              | <b>Previous Surname (if applicable)</b> |
| <b>First</b>                | <b>Middle</b>                           |
| <b>CDSBC Registration #</b> | <b>Birthdate M/D/Y</b>                  |

|   |             |   |     |
|---|-------------|---|-----|
| <b>Contact - Practice</b>   |             | <input type="checkbox"/> I wish to receive mail at this address |     |
| <ul style="list-style-type: none"> <li>• Submit any satellite office address(es) on a separate sheet.</li> <li>• Practice and satellite offices are published in the <i>Directory of Dentists</i>.</li> </ul> |             |   |     |
| Include email in the <i>Directory of Dentists</i>   |             | <input type="checkbox"/> Yes <input type="checkbox"/> No        |     |
| Address   |             |   |     |
| City  |             | Phone   | Fax |
| Province  | Postal Code | Email   |     |

|                       |             |   |       |
|-----------------------|-------------|---|-------|
| <b>Contact – Home</b> |             | <input type="checkbox"/> I wish to receive mail at this address |       |
| Address               |             |   |       |
| City                  |             | Phone   | Fax   |
| Province              | Postal Code | Cell  | Email |

|  |
|--|
| <b>Quality Assurance Requirements</b>  |
| <p>If your NDEB Certificate was issued more than three years ago, have you engaged in the practice of dentistry in another jurisdiction over the preceding three years? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>I have practised as a dentist for _____ hours* during the period of January 1, 2007 through February 28, 2010.</p> <p>* 300 hours minimum for practising registration for 2010-2011. Please provide an estimated number of hours if you do not have precise information.</p> |



**Note:**

- Practise includes work in dental education, research and the provision of clinical care
- CE requirements must be met prior to applying for transfer to practising registration, as though the applicant had been a practising registrant for the period since the dentist held practising registration.

**In what other jurisdiction(s) do you or did you hold a licence to practise dentistry?**

| Jurisdiction | Address | Time Period<br>M/D/Y – M/D/Y |
|--------------|---------|------------------------------|
|              |         |                              |
|              |         |                              |
|              |         |                              |

Provide original (or certified copies of) letters of good standing from **all** licensing jurisdictions in which you **have** or **are** practising since graduation, dated within 30 days of this application

**Privacy and Security**

The information you provide here relates to the operations of the CDSBC under the *Health Professions Act* for the purpose of regulating the practice of dentistry in British Columbia. As a public body under the provisions of the *Freedom of Information and Protection of Privacy Act (FOIPPA)*, CDSBC provides security and confidentiality of your personal information.

**Consent Levels for Release of Information (One box must be selected or the default will be Level 1)**

**Level 1 (Required by law)**

- Only public contact information (practice address, practice telephone number and practice email) may be released to third parties.
- Public contact information plus school, year of graduation and registration year will be released and included in *Directory of Dentists*.
- Personal information is for internal use, for the Provider Registry and any other statutory information required by the Government of B.C.

**Level 2 (Professional organizations only)**

- Includes **Level 1, plus** personal contact information, which may be released to the B.C. Dental Association (BCDA) and the Canadian Dental Association.
- BCDA provide services like the Fee Guide, member newsletters, information on the Pacific Dental Conference and the Dental Profession Advisory Program (DPAP).



**Level 3 (Professional purposes only)**

- Includes **Levels 1 & 2, plus** personal contact information, which may be released to third parties for professional purposes only.
- Professional purposes may include CE opportunities, dental conferences, and information from component societies or about individual CDSBC election campaigns.
- This does not include commercial enterprises providing products or services.

**Malpractice Insurance** (This section must be completed for practising dentists)

Select applicable box. **Coverage of at least \$3,000,000 is mandatory.**

- CDSPI       Other \_\_\_\_\_  
*(enclose copy of certificate of insurance)*

**Application Questions**

All of the following questions **must** be answered. A **written explanation** must be given for all affirmative answers (use a separate sheet if needed). Information provided is **confidential** to CDSBC.

|   |  |
|---|--|
| Have you ever been convicted in Canada or elsewhere of any offence that, if committed by a person registered under the HPA, would constitute unprofessional conduct or conduct unbecoming a person registered under the CDSBC Bylaws? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Are criminal charges pending against you?   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| At present time, are there any investigations, reviews or proceedings taking place in any jurisdiction that could result in the suspension or cancellation of your authorization to practice dentistry?                               | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Has your entitlement to practise dentistry been limited, restricted or subject to conditions in any jurisdiction at any time?   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Does your past conduct demonstrate any pattern of incompetency or untrustworthiness that would make registration contrary to the public interest?   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Have you ever voluntarily surrendered your licence/registration?  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Have you ever practised as a dentist without a licence/registration?  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Do you have a mental or physical condition that could affect your ability to safely practise dentistry? (Examples: mental or physical ailment, psychiatric disorder, addiction, blood borne pathogens)                                | <input type="checkbox"/> Yes <input type="checkbox"/> No |



**Attestation Statement**

I, \_\_\_\_\_ (name of applicant), declare that the answers given to the questions in this application and the information I supplied on this application, are true, complete, and accurate in every respect, and I make this solemn declaration conscientiously believing it to be true, and knowing that it is of the same force and effect as if it were made under oath and by virtue of the *Canada Evidence Act*.

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

CDSBC Transfer Form (January 2010)