



## Certified Dental Assistant Application Instructions for Practising Certification

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**NOTE:** If you are a non-BC dental assisting program graduate, you must first complete the required assessment through this College before applying for certification.

### 2009 Certification Fees for Certified Dental Assistants

Application Fee                      C\$ 225

*Plus the fee below:*

Annual Certification Fees

a) for a Practising CDA:        C\$ 100

**Please submit all completed forms, documents and fees to:**

College of Dental Surgeons of BC  
 500 - 1765 West 8<sup>th</sup> Avenue  
 Vancouver, B.C. V6J 5C6

**Please note all incomplete applications will be returned.**

### CHECKLIST

- Have you answered all questions on the appropriate application form?
- Have you attached a passport-sized head and shoulder photograph to your application?
- Have you enclosed a photocopy of any name change documents if your name has changed?
- Have you submitted a copy of your CDA graduation certificate or diploma?
- If you graduated from a program accredited by the Commission on Dental Accreditation of Canada (CDAC), have you submitted proof of completion of the National Dental Assisting Examination Board (NDAEB) written examination?
- If you graduated from a program not accredited by the CDAC, have you submitted proof of completion of the NDAEB written and Clinical Practice (CPE) examinations?
- Have you signed your application form and had it notarized by a notary public or commissioner for taking oaths who has applied a stamp or seal?
- Have you enclosed both fees for initial registration and certification fee – either a cheque or a completed Visa/MasterCard Payment Option form?
- Have you completed and submitted the Criminal Record Check (CRC) form and included the payment (either a certified cheque or money order made payable to the Minister of Finance or completed the Credit Card Usage Form as provided with the CRC form)?

College of Dental Surgeons



of British Columbia

Suite 500 – 1765 West 8th Ave. Tel: 604-736-3621 Fax: 604-734-9448  
 Vancouver, B.C. V6J 5C6 800-663-9169 866-734-9448  
 www.cdsbc.org

Please attach a  
 passport photo  
 taken within the  
 past 12 months

**Application for Certification  
 as Practising Certified Dental Assistant**  
*under the Health Professions Act*

<b>Surname</b>	<b>Previous Surname (if applicable)</b>
<b>First</b>	<b>Middle</b>
Is the name you are applying under different than the one on your diploma? If yes, attach legal documents verifying the name change.	
<b>Date of Birth</b> – DD/MMM/YY	<b>Place of Birth</b> – City/Province/Country
<b>Gender</b> <input type="checkbox"/> female <input type="checkbox"/> male	

<b>Home Contact (personal)</b>		
Address		City
Home Phone	Province	Postal Code
Daytime Phone	Cell Phone	Email

<b>Colleges or Universities Attended</b>			
Name of Institution	City/Country	Dates Attended from MMM/YY – MMM/YY	Designation Received

<b>Have you been or are you licensed or certified elsewhere as a dental assistant?</b>		
<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, complete the following:		
Jurisdiction	Address	Time Period From DD/MMM/YY – DD/MMM/YY
Provide letters of good standing from all licensing jurisdictions in which you have been or are practising, dated within 30 days of application.		

Have you successfully completed the National Dental Assisting Examining Board (NDAEB) written exam?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
Have you successfully completed the NDAEB Clinical Practice Evaluation exam?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A

All the following questions <b>must</b> be answered. For each "yes" answer, you must provide a <b>written explanation</b> on a separate sheet of paper. This information is <b>confidential</b> to the College of Dental Surgeons of British Columbia.	
Have you ever been charged with or convicted of a crime?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are criminal charges pending against you?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever voluntarily surrendered your license/certificate for any reason other than the avoidance of the renewal fee?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has your entitlement to practise as a dental assistant in any jurisdiction ever been limited, restricted, suspended or cancelled?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is any review, investigation or proceeding either contemplated or taking place in any jurisdiction that could result in the suspension or cancellation of your entitlement to practise as a dental assistant?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does your past conduct demonstrate any pattern of incompetency or untrustworthiness that would make certification contrary to the public interest?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have a mental or physical condition that could affect your ability to safely practise certified dental assisting? (Examples: mental or physical ailment, psychiatric disorder, addiction, blood borne pathogens)	<input type="checkbox"/> Yes <input type="checkbox"/> No

<b>Privacy and Security</b>
The information you provide here relates to the operations of the College under the <i>Health Professions Act</i> for the purpose of regulating the practice of dentistry in British Columbia. As a public body under the provisions of the <i>Freedom of Information and Protection of Privacy Act (FOIPPA)</i> , the College provides security and confidentiality of your personal information.
<b>Consent Levels – One box must be selected or the default will be Level 1</b>
<input type="checkbox"/> <b>Level 1 (Required by law)</b> <ul style="list-style-type: none"> <li>• Includes your name and whether you are a certified dental assistant or former certified dental assistant. Also includes your class of certification, and any additional qualifications you acquired and of which the Registrar has been notified. Any limits or conditions placed on your entitlement to provide the services of a CDA, or any notations or revocation or suspensions on your certification may be released to the public.</li> <li>• Personal information is for internal College use only</li> </ul>
<input type="checkbox"/> <b>Level 2 (Professional organizations only)</b> <ul style="list-style-type: none"> <li>• Includes <b>Level 1 plus</b> personal contact information may be released to the Certified Dental Assistants of B.C. (<a href="http://www.cdabc.org">www.cdabc.org</a>)</li> </ul>
<input type="checkbox"/> <b>Level 3 (Professional purposes only)</b> <ul style="list-style-type: none"> <li>• Includes <b>Levels 1 &amp; 2 plus</b> personal contact information may be released to third parties for professional purposes only <ul style="list-style-type: none"> <li>• Professional purposes may include: continuing education opportunities, dental conferences such as the Pacific Dental Conference, and information from component societies</li> <li>• This does not include commercial enterprises providing products or services</li> </ul> </li> </ul>

### Authorization

- I am applying to be certified as a practising certified dental assistant with the College of Dental Surgeons of British Columbia (the "CDSBC") pursuant to the Bylaws made under the *Health Professions Act*. In consideration of the CDSBC's processing of my application, by my signature below, I authorize the CDSBC to make reasonable and lawful enquiries about me, including enquiries seeking confidential or personal information (in documentary form or otherwise) from any regulatory authority, hospital, educational program, institution or law enforcement agency (collectively, the "Certification-Related Information"), and to then consider and use the Certification-Related Information, all for the sole purpose of determining my fitness for certification as a practising certified dental assistant in British Columbia.
- I recognize that those who, in good faith, furnish Certification-Related Information to the CDSBC in connection with my application for certification have reasonable expectations that such Certification-Related Information will be kept confidential.
- I further understand that the CDSBC may take disciplinary action against me, including action to revoke my certification, if I have, by omission or commission, knowingly given false or misleading information in the course of completing this application for certification.

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

\_\_\_\_\_  
Date

FORM 18

### Statutory Declaration

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 \_\_\_\_\_

DECLARED before me at the city of \_\_\_\_\_, in (country) \_\_\_\_\_,

this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.

A Commissioner for Oaths or Notary Public \_\_\_\_\_

(Must include a stamp or seal of Commissioner for Oaths or Notary Public)



## COMMISSIONER FOR OATHS

### INFORMATION SHEET

According to Section 60 of the *BC Evidence Act*, the following persons are, because of their office or employment, commissioners for taking affidavits for British Columbia:

- a) a judge of a court in British Columbia;
- b) justices;
- c) registrars, deputy registrars, district registrars and deputy district registrars of the Supreme Court;
- d) practising lawyers as defined in section 1 (1) of the *Legal Profession Act*;
- e) notaries public;
- f) the local government corporate officer and that person's deputy;
- g) the secretary treasurer of a board of school trustees;
- h) the directeur général of a francophone education authority as defined in the *School Act*;
- i) coroners;
- j) government agents and deputy government agents;
- k) other classes of office holder or employment the Attorney General prescribes.

Any questions should be addressed to:

Order in Council Office  
Ministry of Attorney General  
Room 029, Parliament Buildings  
Victoria, BC V8V 1X4

Tel: 250-387-5378  
Fax: 250-387-4349



# Consent to a CRIMINAL RECORD CHECK

**IMPORTANT:** Please read information and instructions on Page 2. Ensure payment is included with form.

Schedule Type\*:  A  B  C  D  E  F

## PART 1 – APPLICANT INFORMATION – To be completed by all schedule types.

Last Name: \_\_\_\_\_ Full First: \_\_\_\_\_ Full Middle: \_\_\_\_\_

Birth Date: \_\_\_\_\_ (yyyy/mm/dd) Gender:  Male  Female Birth Place: \_\_\_\_\_ (City, Province/State, Country)

OTHER NAMES USED OR HAVE USED: (e.g., maiden name, birth name, or previous married name)

Surname: \_\_\_\_\_ First: \_\_\_\_\_ Middle: \_\_\_\_\_

Surname: \_\_\_\_\_ First: \_\_\_\_\_ Middle: \_\_\_\_\_

Surname: \_\_\_\_\_ First: \_\_\_\_\_ Middle: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ Province: \_\_\_\_\_ Country: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Contact Phone : ( \_\_\_\_\_ ) \_\_\_\_\_ BC Driver Licence # : \_\_\_\_\_

## PART 2 – ORGANIZATION INFORMATION – To be completed by all, except Schedule F.

### Section A

Please complete this section if you have an ID number from Criminal Records Review Program

Organization Name: College of Dental Surgeons of BC  
Company / Ministry / Childcare Resource Referral Program (CCRRP) / Health Authority / Governing Body / Education Institution / Office of Independent Schools

ID Number (provided by the Criminal Records Review Office): 8

If you are unable to provide an ID Number please complete Section B.

### Section B

Organization Name: N/A Name of Subcontractor (if applicable): N/A

Mailing Address: N/A

City: N/A Province: N/A Country: N/A Postal Code: N/A

Office Phone: ( N/A ) N/A Fax: ( N/A ) N/A

Applicant's Employment Position / Job Title (if applicable): N/A

Contact / Licensing Officer Name (if applicable): N/A

Governing Body Licence or Registration # (if applicable): N/A

## PART 3 – Complete for Schedule D Only

Child Care Facility Name: \_\_\_\_\_

## CONSENT FOR RELEASE OF INFORMATION AND ACKNOWLEDGEMENTS:

I have read and understand the Consent for Release of Information and Acknowledgements on Page 2. I hereby consent to these terms as indicated by my signature below:

Applicant Signature

Parent or Guardian Signature for Applicant Under 19 Years of Age

Date Signed



# Consent to a Criminal Record Check (Schedule A, B, C, D, E or F)

## INFORMATION and INSTRUCTIONS

Page 1 is set up with 'form fields' so you may complete it at your computer then print the number of copies required. You may also complete the form by hand, but please print clearly using dark ink. Processing delays will result if form is submitted incomplete, incorrect or if information cannot be read clearly. For information contact the Criminal Records Review Program at (250) 387-6981 or toll-free 1-800-663-7867.

### SCHEDULE TYPES

**Schedule A:** use if the employee is working with children and does not qualify under any of the following schedules within the scope of the Criminal Records Review Act. The employer retains the original signed consent form.

**Schedule B:** use if the individual is a) an applicant for membership to a governing body or b) is applying for or has certification or a letter of permission under the Independent School Act or c) is a registered student with an education institution with a practicum component involving work with children which leads to certification by a governing body. See website [www.pssg.gov.bc.ca/criminal-records-review/act/who.htm](http://www.pssg.gov.bc.ca/criminal-records-review/act/who.htm) for a complete list of Governing Bodies covered under the Criminal Records Review Act. The governing body, office of independent schools or the education institution retains the original signed consent form.

**Schedule C:** use if the individual is a volunteer, a resident aged 12 or older, or is an owner/operator of a licence-not-required child care facility. Use the Application to Waive Fees if the individual is a resident 12-18 years (inclusive) at a licence-not-required child care facility. The CCRRP retains the original signed consent form.

**Schedule D:** use if the individual is an owner/operator applying for a child care facility licence, or a resident age 12 or older at a licensed child care facility. The local health authority retains the original signed consent form.

**Schedule E:** use if the individual is an employee or a volunteer at a licensed child care facility. The employer retains the original signed consent form.

**Schedule F:** use if the individual is a student (ECE college level or high school) on work placement at a child care facility, or a child care substitute applying for registration on the Short-term Registry. (Use the Application to Waive Fees only if the individual is a B.C. high school student enrolled at a B.C. high school on a school-arranged voluntary work placement/work experience in a child care facility.) The individual retains the original signed consent form.

### CHECKLIST for Applicant

- I understand which schedule type pertains to me.
- At the top of page one of the consent form, I have checked off which Schedule Type (A,B,C,D,E or F) I am submitting for a Criminal Record Check.
- I have completed all the applicable sections clearly and legibly.
- I have read and understand the Consent for Release of Information and Acknowledgements and information regarding the Freedom of Information and Privacy Act (FOIPPA) — (outlined below).
- I have signed and dated the Consent for Criminal Record Check form.
- Payment: **I have provided the \$20 processing fee (non-refundable) by:**
  - 1) Visa or MasterCard – and have completed the Credit Card Usage Form ([www.pssg.gov.bc.ca/criminal-records-review/forms/CreditCard.pdf](http://www.pssg.gov.bc.ca/criminal-records-review/forms/CreditCard.pdf))
  - 2) Certified cheque or money order made payable to the Minister of Finance; or
  - 3) I have not included the \$20 payment but have completed and attached an Application for Fee Waiver ([www.pssg.gov.bc.ca/criminal-records-review/forms/FeeWaiver.pdf](http://www.pssg.gov.bc.ca/criminal-records-review/forms/FeeWaiver.pdf) - see information on the website to determine eligibility for a fee waiver).
- I understand that my employer or organization will retain the originals of the forms I have completed and will forward a copy with the processing fee to the Criminal Records Review Program on my behalf unless I am a Schedule F then I am to retain the original signed consent form.

### CHECKLIST for Organization (Company/Ministry/CCRRP/Health Authority/Governing Body/Education Institution/ Office of Independent Schools)

- The employee/applicant will provide you with the original, completed and signed consent form and applicable attachments.
- Retain the original form(s).
- Forward a copy of the form(s), along with payment, to the Criminal Records Review Program by:
  - 1) **MAIL** : Criminal Records Review, Ministry of Public Safety and Solicitor General, PO Box 9217 Stn Prov Govt, Victoria BC V8W 9J1  
or
  - 2) if the fee is being paid by credit card, you have the option to **FAX** the credit card authorization form with the completed form to: 250 356-1889.

### CONSENT FOR RELEASE OF INFORMATION AND ACKNOWLEDGEMENTS PURSUANT TO THE B.C. CRIMINAL RECORDS REVIEW ACT

- I hereby consent to a check for records of criminal convictions to determine whether I have a conviction or outstanding charge for any relevant offences under the Criminal Records Review Act;
- Where the results of this check indicate that a criminal record or outstanding charge for a relevant offence may exist, I agree to provide my fingerprints to verify any such criminal record.
- The Deputy Registrar will notify me and my organization that I have an outstanding charge or conviction for any relevant offence(s) and the matter has been referred to the Deputy Registrar;
- The Deputy Registrar will determine whether or not I present a risk to physical or sexual abuse to children;
- The Deputy Registrar's determination will be disclosed to my organization and it will include consideration of any relevant offence for which I have received a pardon;
- If I am charged with or convicted of a relevant offence at any time subsequent to the criminal record check authorized herein, I further agree to report the charge or conviction to my organization and provide my organization, in a timely manner, with a new signed Consent to a Criminal Record Check form.

Page 2 of 2

**FREEDOM OF INFORMATION AND PROTECTION OF PRIVACY ACT (FOIPPA):** The information requested on this form is collected under the authority of the Criminal Records Review Act and in the case of child care facilities, the Community Care Facility Act, and the regulations which govern both these acts. The information provided will be used to fulfill the requirements of the Criminal Records Review Act for the release of criminal records information and is in compliance with the FOIPPA.



# Criminal Records Review Program Application for Pre-Authorized CREDIT CARD USAGE

To be completed if paying by credit card.

**Directions:** You may complete the form fields at your computer, print, then sign and date *OR* print the form out and complete using a dark ink pen, printing clearly and carefully. The form must be signed and dated and all information must be complete in order for the record check to proceed. Incomplete forms will be returned.

## PART A – CREDIT CARD PAYMENT AUTHORIZATION

I authorize the use of the following credit card to cover criminal record check(s) fees as follows (**check one**):

Payment Type:  Visa  Mastercard

- I hereby authorize to deduct \$20.00 for each applicant listed in Part B — \$ 20.00 (total payment authorized).
- I wish to establish a drawdown account.
- I wish to replenish an existing drawdown account.

Credit Card Number: \_\_\_\_\_ Expiry Date: \_\_\_\_\_ / \_\_\_\_\_ (Month / Year)

Print Cardholder's Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Signature of Cardholder: \_\_\_\_\_ Date signed: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
(Year / Month / Day)

Address: \_\_\_\_\_ Telephone No: \_\_\_\_\_  
Postal Code \_\_\_\_\_

Name of Organization: College of Dental Surgeons of BC

## PART B – INDIVIDUAL(S) REQUIRING A CRIMINAL RECORD CHECK:

Clearly print the names of individuals requiring a criminal record check and for whom applications are attached (a list of names is not required for those establishing or replenishing a Draw Down account).

Surname	First Given Name	Middle Name(s)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**CHECK HERE** if you require more space and continue on a separate sheet, attaching it securely to this form.

## PART C – FOR SECURITY PROGRAMS USE ONLY:

Invoice # \_\_\_\_\_ Trans # or Approval # \_\_\_\_\_ Completed by \_\_\_\_\_ Date \_\_\_\_\_

PSSG 08-000 10/2008



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of British Columbia



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[www.cdsbc.org](http://www.cdsbc.org)

### VISA/MasterCard Payment Option

Name of Dentist or CDA:		College Registration #
<input type="checkbox"/> VISA	<input type="checkbox"/> MasterCard	Expiry Date:
Card Number:		
Cardholder's Name (please print):		
Cardholder's Signature:		Amount \$

Your authorizing signature is required; therefore, payment by telephone is NOT an option



# Standards of Practice for Dentists and Certified Dental Assistants in British Columbia

The following standards describe the responsibilities of dentists and certified dental assistants (CDAs) in providing dental care to the public in B.C.

## 1

### Patient-Centred Dental Care

- Put the interests of patients before the interests of the dentist or CDA in providing safe, professional, quality patient care.
- “Do no Harm”.
- Respect the patient’s right to confidentiality.
- Respect the patient’s right and ability to make informed choices regarding dental care.

## 2

### Unique Body of Knowledge

- Base dental practice on a unique, scientifically based body of knowledge and expertise.
- Practise according to evidence-based and peer-supported principles.

## 3

### Competent Application of Knowledge

- Competently apply knowledge in assessing, treating and managing the care of the patient.

- Assess outcomes of care provided where possible.
- Maintain competence by undertaking continuous learning and professional development.

## 4

### Professional Ethics

- Practise in accordance with the ethical guidelines for the profession.

## 5

### Professional Responsibility and Accountability

- Maintain accountability in the public interest.
- Ensure that practice meets the legislative requirements and professional standards of the profession.
- Assume primary responsibility for maintaining own competence and fitness to practise.

**College of Dental Surgeons of British Columbia**

500 – 1765 West 8th Avenue, Vancouver, BC V6J 5C6 Tel: 604 736-3621 Toll-free tel: 1 800 663 9169  
Fax: 604 734-9448 Toll-free fax: 1 866 734 9448 Website: [www.cdsbc.org](http://www.cdsbc.org)

*Regulating dentists and certified dental assistants in the public interest*