500 – 1765 West 8th Avenue
Vancouver BC Canada V6J 5C6
www.cdsbc.org

Phone 604 736 3621
Toll Free 1 800 663 9169
Facsimile 604 734 9448

CDSBC | College of Dental Surgeons of British Columbia

# APPLICATION INSTRUCTIONS FOR FULL REGISTRATION AS A DENTIST

## Contents

- Form 4: Application for Full Registration as a Dentist in British Columbia
- Form 2: Statutory Declaration
- Quality Assurance Form
- Commissioner for Oaths Information Sheet
- Criminal Record Check Authorization
- Standards of Practice for Dentists and Certified Dental Assistants in British Columbia Information Sheet

### Application & Registration Fees

**Application Fee** (non-refundable) ______ C$2,000

**Registration Fee for 2012–2013**
(non-refundable after registration is granted)

March 1 – August 31 ______ C$2,522

Half-year pro-ration
September 1 – February 28 ______ C$1,261

New Graduates pro-ration
(If received between June 1 to September 1) ______ C$1,892

Fees may be paid by cheque or money order made payable to CDSBC, or cash if paid in person at the CDSBC office Monday – Friday from 8:00 am – 4:30 pm. If paying by cheque or money order, note that separate payments are required for each of the application and registration fees.

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

College of Dental Surgeons of BC
500 – 1765 West 8th Avenue
Vancouver, BC V6J 5C6

## Checklist

- ☐ Have you answered all questions on the application forms?
- ☐ Have you attached a passport-sized head and shoulder photograph to your application?
- ☐ Have you enclosed a copy of name change documents if your name has changed?
- ☐ Have you submitted both a copy of your dental degree and your National Dental Examining Board (NDEB) certificate?
- ☐ Have you signed your application form and had it and the statutory declaration notarized by a Commissioner for Oaths who has applied a stamp or seal?
- ☐ Have you enclosed separate payments for the application and registration fees?
- ☐ Have you completed and enclosed the Criminal Record Check (CRC) form and included the payment?
- ☐ Have you submitted proof of your malpractice insurance?
- ☐ If licensed in another jurisdiction, have you submitted
  - a Letter or Certificate of Standing from that licensing or regulatory authority? (download application from www.cdsbc.org)
  - a completed Quality Assurance Form?
  - have you enclosed a CE transcript from that licensing or regulatory authority?

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

Attach a passport sized photo taken within the past 12 months

Photo must be attached prior to notarization

# APPLICATION FOR FULL REGISTRATION – DENTIST

**Surname** ______________________________

**Previous Surname (if applicable)** ______________________________

**First** ______________________________

**Middle** ______________________________

Is the name above different from the one on your degree? If yes, provide a copy of legal documents certifying name change, i.e. marriage certificate, legal name change decree.

FOR OFFICE USE ONLY:
Registration #: ______________________________

**Date of birth** – M/D/Y ______________________________

**Place of birth** – City/Province/Country ______________________________

**Gender** ☐ female ☐ male

**Practice** – Submit any satellite office address(es) on a separate sheet

Address ______________________________ Phone ______________________________

City ______________________________ Fax ______________________________

Province ______________ Postal Code ______________ Email ______________________________

☐ Include email in *Directory of Dentists*

**Home**

Address ______________________________ Phone ______________________________

City ______________________________ Fax ______________________________

Province ______________ Postal Code ______________ Cell ______________________________

Personal Email (for confidential/personal information from CDSBC) ______________________________

**I wish to receive mail from CDSBC** (check one only)

☐ at my practice address ☐ at my home address

**Privacy and Security**

The information you provide here relates to the operations of 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 the *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)**

- **Level 1 plus** personal contact information, which may be released to the BC Dental Association (BCDA) and the Canadian Dental Association (CDA).
- BCDA provides services such as the Fee Guide, member newsletters, information on the Pacific Dental Conference and the Dental Profession Advisory Program (DPAP).

☐ **Level 3 (Professional purposes only)**

- **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.
- Note: CDSBC does not release information to commercial enterprises providing products or services.

**Have you previously been registered with this College in any capacity?** ☐ Yes ☐ No

If yes, provide registration or permit number: ______________________________

**Dental Education** – Provide copy of degree(s)

| Name of Institution | City/Country | Dates attended M/D/Y – M/D/Y | Degree Received |
|---|---|---|---|
| | | | |
| | | | |

**Do you have a National Dental Examining Board of Canada Certificate?** ☐ Yes ☐ No

If yes, provide a copy.

Certificate number ______________________________ Date Received M/D/Y ______________

**Quality Assurance**

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? If yes, complete the Continuous Practice portion of the attached Quality Assurance form.

Have you completed dental continuing education during the past three years? If yes, complete the CE portion of the attached Quality Assurance Form and attach a transcript from your licensing jurisdiction(s).

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

| Jurisdiction | Address | Time Period M/D/Y – M/D/Y |
|---|---|---|
| | | |
| | | |
| | | |

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

## Professional Liability Insurance

Select applicable box. Coverage of at least $3,000,000 for British Columbia 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.

| Question | Yes | No |
|---|---|---|
| Have you ever been convicted in Canada or elsewhere of any offence that, if committed by a person registered under the *Health Professions Act*, would constitute unprofessional conduct or conduct unbecoming a person registered under the CDSBC Bylaws? | ☐ Yes | ☐ No |
| Are criminal charges pending against you? | ☐ Yes | ☐ 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 practise dentistry? | ☐ Yes | ☐ No |
| Has your entitlement to practise dentistry been limited, restricted or subject to conditions in any jurisdiction at any time? | ☐ Yes | ☐ No |
| Does your past conduct demonstrate any pattern of incompetency or untrustworthiness that would make registration contrary to the public interest? | ☐ Yes | ☐ No |
| Have you ever voluntarily surrendered your licence/registration? | ☐ Yes | ☐ No |
| Have you ever practised as a dentist without a licence/registration? | ☐ Yes | ☐ 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) | ☐ Yes | ☐ No |

## Authorization and Oath

- I am applying to register with the College of Dental Surgeons of British Columbia ("CDSBC") under the *Health Professions Act* and the Bylaws made under the *Health Professions Act*. In consideration of CDSBC's processing of my application, by my signature below, I authorize 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 "Registration-Related Information"), and to then consider and use the Registration-Related Information, all for the sole purpose of determining my fitness for registration as a dentist in British Columbia.
- I recognize that those who, in good faith, furnish Registration-Related Information to CDSBC in connection with my application for registration have reasonable expectations that such Registration-Related Information will be kept confidential.
- I further understand that CDSBC may take disciplinary action against me, including action to revoke my registration, if I have, by omission or commission, knowingly given false or misleading information in the course of completing this application for registration.
- I am aware of the *Health Professions Act* of British Columbia and the CDSBC Bylaws and do solemnly declare that I will uphold the honour and dignity of the profession and adhere to the *Health Professions Act* of British Columbia and the CDSBC Bylaws.

## 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 ______________________________

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)

# STATUTORY DECLARATION (DENTISTS/STUDENT PRACTITIONERS)

IN THE MATTER OF AN APPLICATION FOR REGISTRATION WITH THE COLLEGE OF DENTAL SURGEONS OF BC, IN THE PROVINCE OF BRITISH COLUMBIA, CANADA

I, ______________________________________________________________ ,

of (City/Country) ___________________________________________________

do solemnly declare that:

1. I am a person of good character.
2. I am aware of the *Health Professions Act* of British Columbia and the regulations and Bylaws of the College of Dental Surgeons of British Columbia made pursuant to that *Act*.
3. I will practise at all times in compliance with the *Health Professions Act* of British Columbia and the regulations and Bylaws of the College of Dental Surgeons of British Columbia made pursuant to that *Act*.

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 made under oath.

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)

THIS FORM MUST BE SIGNED AND STAMPED WITH THE NOTARY SEAL.
APPLICATION MUST BE COMPLETE, WITH PHOTO ATTACHED, PRIOR TO NOTARIZATION.

500 – 1765 West 8th Avenue
Vancouver BC Canada V6J 5C6
www.cdsbc.org

Phone 604 736 3621
Toll Free 1 800 663 9169
Facsimile 604 734 9448

# QUALITY ASSURANCE FORM

## Continuous Practice

Please provide details of continuous practice (defined as at least 900 hours over the preceding three years. Practice includes work in dental education, research and the provision of clinical care.

| From: (M/Y) To: (M/Y) | Practice Location | # of Hours |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

## Continuing Education (CE)

Please provide a summary of continuing education credits received over the preceding three years *and* attach a copy of your continuing education transcript from your licensing/regulatory authority.

| Year | # of Credit Hours Obtained |
|---|---|
| | |
| | |
| | |

**Name of Applicant:** ______________________________

**Signature** ______________________________ **Date** – M/D/Y ____________

500 – 1765 West 8th Avenue
Vancouver BC Canada V6J 5C6
www.cdsbc.org

Phone 604 736 3621
Toll Free 1 800 663 9169
Facsimile 604 734 9448

# 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.

**Note:** For persons outside of British Columbia, persons or agencies equivalent to the above in other provinces or states may provide legal notarization of CDSBC application documents.

Ministry of Public Safety and Solicitor General

Criminal Records Review Program

# Consent to a CRIMINAL RECORD CHECK

For working with children and / or vulnerable adults

**IMPORTANT:** Please read information and instructions on Page 2. To avoid processing delays, ensure all relevant fields are complete and payment is included with the form.

**Schedule Type*:** ☐ A ☑ B ☐ C ☐ D ☐ E ☐ F

**WORKS WITH (choose one):** ☐ children ☐ vulnerable adults ☑ children and vulnerable adults

If you are unsure which 'works with' category to check, please contact your organization.

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

Last Name: ____________ First: ____________ 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** Complete this section if you have been provided with an ID number from Criminal Records Review Program.

Organization Name: College of Dental Surgeons of BC

*Employer / Childcare Resource Referral Program (CCRRP) / Health Authority / Governing Body / Education Institution / Office of Independent Schools*

Organization Contact Name or Title (the person to receive the result of the check): ____________

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

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

Organization Name: N/A

Organization Contact Name or Title (the person to receive the result of the check): N/A

Mailing Address (result of the check is sent here): N/A

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

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

Applicant's Position / Job Title with Organization: N/A

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

## PART 3 – Schedule D Only must provide:

Licensed Child Care or Adult 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 |
|---|---|---|
| | | |

PSSG10-031 / April 2011

**Ministry of Public Safety and Solicitor General**
Policing and Security Programs
Security Programs Division
Criminal Records Review Program

**Mailing Address:**
P.O. Box 9217 STN PROV GOVT
Victoria, BC V8W 9J1
**Fax:** (250) 356-1889
www.pssg.gov.bc.ca/criminal-records-review

# 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 (including specific instructions for each schedule type)**

**Schedule A**: use if the individual is an employee working with children and / or vulnerable adults and does not meet any description of schedules B, C, D or E. The employer retains the original signed consent form.

**Schedule B**: use if the individual is a) applying for membership or is a registered member of a B.C. governing body, or b) is applying for, or has certification, or a letter of permission to teach through the Office of Inspector of Independent Schools, B.C. Ministry of Education, or c) is a registered student in a post secondary program with a practicum component involving work with children and / or vulnerable adults. See website www.pssg.gov.bc.ca/criminal-records-review/who-qualifies/index.htm for a complete list of Governing Bodies covered under the Criminal Records Review Act. Either the governing body, Office of Inspector of Independent Schools or the post secondary institution retains the original form.

**Schedule C:** use if the individual is a volunteer, a resident age 12 or older, or a manager or owner / operator of a licence-not-required child care facility. The child care facility must apply for registration or be registered with their regional provincial Child Care Resource and Referral program. The local Child Care Resource and Referral Program must complete PART 2 of this form and retains the original signed consent form.

**Schedule D:** use if the individual is a manager or owner operator applying for or already holds a child care or adult care (vulnerable adults) facility licence, or is the manager's or owner operator's family member age 12 or older living in the facility. The local Health Authority, Community Care and Assisted Living facilities licensing office must complete PART 2 of this form and retains the original signed consent form. Individuals must also complete PART 3.

**Schedule E**: use if the individual is an employee or a volunteer at a child care or adult care (vulnerable adults) facility, licensed under the Community Care and Assisted Living Act which is administered by local health authority community care facility licensing offices. The manager or owner / operator of the facility keeps 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, or a child care worker working at multiple facilities applying for registration on the Short-term Registry or an adult care facility licensed under the Community Care and Assisted Living Act. The applicant keeps the original form. NOTE, effective January 1, 2012 ECE students will be considered Schedule B.

**CHECKLIST for Applicant**

- ☐ I understand which 'schedule type' and which 'works with' category pertains to me (if this is not clear, please contact your organization).
- ☐ I have checked off which Schedule Type (A,B,C,D,E or F) I am submitting for a Criminal Record Check and indicated which 'works with' category.
- ☐ 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:**
  - ☐ Visa or MasterCard – and have completed the Credit Card Usage Form – www.pssg.gov.bc.ca/criminal-records-review/shareddocs/credit-card.pdf
  - ☐ Certified cheque or money order made payable to the Minister of Finance. **NOTE: Personal cheques are NOT accepted.**
  - ☐ My organization will pay the $20.00 processing fee
  - ☐ I have not completed payment, but have completed the Fee Waiver (attached) – see www.pssg.gov.bc.ca/criminal-records-review/apply/index.htm
- ☐ 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**

- ☐ 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 either method below:
  1) **MAIL** : Criminal Records Review, Ministry of Public Safety and Solicitor General, PO Box 9217 Stn Prov Govt, Victoria BC V8W 9J1
  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 or specified offence(s) under the Criminal Records Review Act;
- I hereby authorize the release to the Deputy Registrar any documents in the custody of the police, the court and crown counsel relating to an outstanding charge or conviction of any relevant or specified offence(s) as defined under the Criminal Records Review Act.
- Where the results of this check indicate that a criminal record or outstanding charge for a relevant or specified offence(s) 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 or specified 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 and / or physical, sexual or financial abuse to vulnerable adults as applicable.
- The Deputy Registrar's determination will be disclosed to my organization and it will include consideration of any relevant or specified offence(s) for which I have received a pardon.
- If I am charged with or convicted of a relevant or specified offence(s) 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.



**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.

Ministry of Public Safety and Solicitor General

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. Credit card information should not be e-mailed. Mail or fax this form to the Criminal Records Review Program (address below).**

## 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 — $ ____________ (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 Organzation: College of Dental Surgeons of BC

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

Clearly print the names of individuals requring 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) |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

## PART C – FOR SECURITY PROGRAMS USE ONLY:

Invoice # ______________ Trans # or Approval # ______________ Completed by ________ Date ________

PSSG 08-000 01/2010

**Ministry of Public Safety and Solicitor General**
Policing and Security Programs
Security Programs Division
Criminal Records Review Program

**Mailing Address:**
P.O. Box 9217 STN PROV GOVT
Victoria, BC V8W 9J1
**Fax:** (250) 356-1889
www.pssg.gov.bc.ca/criminal-records-review

CDSBC | College of Dental Surgeons of British Columbia

# 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
Phone 604 736 3621
Toll Free 1 800 663 9169
Fax 604 734 9448
Toll Free Fax 1 866 734 9448
www.cdsbc.org