



CERTIFIED DENTAL ASSISTANT REQUEST FOR EXTENSION

Certification Class – Select one only

Limited Certification Temporary Certification Temporary Provisional Certification

Surname _____

First _____ **Middle** _____

Preferred Name _____

Date of birth – M/D/Y _____ **CDSBC Certification Number** _____

Home

You must provide a valid home address and contact information, including an email address.

Address _____ Phone _____

City _____ Cell _____

Province _____ Postal Code _____

Main Email (for confidential/personal information from CDSBC) _____

Practice

Address _____ Phone _____

City _____ Province _____

Postal Code _____ Email _____

Period for extension requested (please indicate)

1 month – C\$12.92 2 months – C\$25.84 3 months – C\$38.76 4 months – C\$51.68

Certification required for the calendar month(s) of: _____

Reason for extension request

Signature of Applicant _____ **Date** – M/D/Y _____

CDSBC USE ONLY

Approved by _____ **Date** – M/D/Y _____

MAKE SURE YOU HAVE SIGNED THIS FORM.

Certification Extension Fees

- 1 month certification** _____ C\$12.92
- 2 months certification** _____ C\$25.84
- 3 months certification** _____ C\$38.76
- 4 months certification** _____ C\$51.68

Please indicate how you would like to pay by checking off the appropriate box below:

- By Credit Card – Once your application has been received and reviewed, you will receive an email notification to pay the extension fee.
- By Cheque or Money Order – enclosed with application.

Please submit, by mail or courier, all completed forms, documents and fees (if not paying online) to:

College of Dental Surgeons of BC
110 – 1765 West 8th Avenue
Vancouver, BC V6J 5C6

NOTE: Please ensure you submit all required information. Incomplete information will delay the processing of your application. Incomplete applications may be returned.

PLEASE RETURN THIS PAGE ALONG WITH THE APPLICATION.