



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 #** _____

Home

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

Address _____ Phone _____

City _____ Cell _____

Province _____ Postal Code _____

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

Practice

Address _____ Phone _____

City _____ Province _____

Postal Code _____ Email _____

Period for extension requested (please indicate)

1 month – C\$10.83 2 months – C\$21.66 3 months – C\$32.49

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.



APPLICANT CREDIT CARD AUTHORIZATION FORM

Certification required for the calendar months of:

Applicant name: _____

VISA Mastercard

Card number: _____ **Expiry:** _____

Choose one of the following certification fees:

1 month certification:

C\$10.83

2 months certification:

C\$21.66

3 months certification:

C\$32.49

Cardholder's name (please print): _____

Cardholder's signature: _____

Payment by phone and debit-credit card is not available. Your signature is required to authorize payment.

MAKE SURE YOU HAVE SIGNED THIS FORM.