



## APPLICATION INSTRUCTIONS FOR REINSTATEMENT PRACTISING CERTIFIED DENTAL ASSISTANT

This package is for Certified Dental Assistants who have lapsed certification over 60 days and wish to reinstate their certification with CDSBC. **Note: If your certification has been lapsed for less than 60 days, please contact CDSBC.**

### Contents

- Form 25: Application for Reinstatement as a Practising Certified Dental Assistant
- Form 18: Statutory Declaration (CDA)
- Commissioner for Oaths Information Sheet
- Criminal Record Check Authorization

### Checklist

- Have you answered all questions on the application forms?
- Have you attached a passport-sized head and shoulder photograph to your application?  
**Note:** Photo must be attached to application prior to notarization.
- Have you enclosed a copy of name change documents if your name has changed?
- Have you signed and dated your application form?
- Have you enclosed payment for the reinstatement, Criminal Record Check and certification fees?

- Have you completed and enclosed the Criminal Record Check (CRC) Authorization form? CDSBC will forward the CRC Authorization to the Ministry of Public Safety and Solicitor General on your behalf.
- Have you had the following **notarized** by a Commissioner for Oaths who has applied a stamp or seal?
  - Your **photo** on page 1 of the application.
  - The Statutory Declaration.
  - A photocopy of your **government issued photo identification** which displays your name, date of birth, signature and photo (ie. driver's license or passport). This is required for your CRC.
- If licensed or previously licensed in another jurisdiction, have you:
  - requested a Letter of Standing from that licensing or regulatory authority?
  - submitted a completed Quality Assurance Form?

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

## Fees

**Reinstatement Fee** (non-refundable) \_\_\_\_ C\$159

**Consent for a Criminal Record Check** C\$28

**Certification Fee for 1 March 2021 to 28 February 2022** (non-refundable after certification is granted)

If certification is finalized between  
1 March – 31 August \_\_\_\_\_ C\$155

Half-year pro-ration – if certification is finalized  
between September 1 – February 28 \_\_\_\_ C\$83

**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 reinstatement and Criminal Record Check fees online. Once your certification is ready to be finalized, you will receive a second email notification to pay the certification fee online.
- By Cheque or Money Order – enclosed with application.

If paying by cheque or money order, note that the reinstatement and Criminal Record Check fees may be combined but a separate payment of the certification fee is required.

**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

**PLEASE RETURN THIS PAGE ALONG WITH THE APPLICATION.**


**CDSBC**

 College of Dental Surgeons  
of British Columbia

## APPLICATION FOR REINSTATEMENT PRACTISING CERTIFIED DENTAL ASSISTANT

**Surname** \_\_\_\_\_

**Previous Surname (if applicable)** \_\_\_\_\_

**First** \_\_\_\_\_

**Middle** \_\_\_\_\_

**Preferred Name** \_\_\_\_\_

If the name you are applying with is different than the one on any of your supporting documents, you must provide a copy of legal documents certifying the name change (ie. marriage certificate, legal name change decree).

**Date of birth** – M/D/Y \_\_\_\_\_ **Gender**     female     male

**CDSBC Certification Number** \_\_\_\_\_

**Place of birth** – City/Province/Country \_\_\_\_\_

**Identification** – A **notarized** copy of government issued ID is required. (select one).

 Drivers license number \_\_\_\_\_ issued by (Prov/State) \_\_\_\_\_

 BC Identification Card number \_\_\_\_\_

 Passport number \_\_\_\_\_ issued by (Country) \_\_\_\_\_

### 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 information from CDSBC) \_\_\_\_\_

### Practice

Address \_\_\_\_\_ Phone \_\_\_\_\_

City \_\_\_\_\_ Province \_\_\_\_\_

Postal Code \_\_\_\_\_ Email \_\_\_\_\_

 Attach a passport sized  
photo taken within the  
past 12 months

**Photo must be  
attached prior to  
notarization**

 Notary Stamp/  
Seal here

**(must overlap  
photo)**

## Privacy and Security

CDSBC must collect and manage certain personal information to fulfill its regulatory purpose as set out in the *Health Professions Act* (the “HPA”). Additionally, CDSBC is designated as a public body under the Freedom of Information and Protection of Privacy Act (FOIPPA). CDSBC collects and manages information in accordance with the HPA, FOIPPA, and other applicable laws.

Some of the information CDSBC collects must be publicly accessible pursuant to the *HPA*. You may also wish for CDSBC to provide your contact information to other professional organizations for the purposes stated. Please provide your instructions below:

### Consent Levels for Release of Information

The HPA and the CDSBC Bylaws require that certain information be included in the CDSBC register and be publicly accessible. **Level 1** includes a list of the information which will appear in the register and on the CDSBC web site. This is mandatory by law.

**Level 1, below, is the minimum required however you may wish to allow for other use of your information as outlined below in Level 2 and Level 3. Please check one box below.**

**Level 1 (Minimum required by law)**

- Your name, class of certification and any additional qualifications recognized by CDSBC which you have acquired and of which the Registrar has been notified; and
- Any limits or conditions placed on your entitlement to provide the services of a CDA, and any notations or revocation or suspensions on your certification.

**Level 2**

This consent level, in addition to **Level 1**, allows for personal contact information to only be released and used by CDSBC and the Certified Dental Association of British Columbia (CDABC).

**Level 3**

This consent level, in addition to **Levels 1 & 2**, allows for personal contact information (mailing address) to be released to selected third parties for professional purposes only.

- Professional purposes may include CE opportunities, dental conferences, and information from component societies.
- This does not include commercial enterprises providing products or services.

**Have you ever been or are you licensed/registered/certified elsewhere as a healthcare provider?**

Yes  No If yes, complete the following:

Jurisdiction	Address	Time Period From M/D/Y – M/D/Y

**IMPORTANT: If you are or have ever been registered/licensed in another province or country, please contact that provincial or national regulatory body to request a Certificate of Standing or Letter of Standing for your CDSBC application. The Certificate must be delivered directly to CDSBC from the licensing/regulating body in a sealed envelope.**

**The Certificate is valid for up to 30 days from the date that it was issued. If an applicant does not have their registration/certification process completed within 30 days from the date of issue, a new Certificate will be required.**

**Quality Assurance Requirement**

Have you engaged in the practice of dental assisting in another jurisdiction over the preceding three years?

Yes  No

If yes, where? \_\_\_\_\_

If yes, please provide information on Continuous Practice hours and Continuing Education credits.

**Continuous Practice**

Please provide number of continuous practice as a licensed/regulating dental healthcare provider (defined as 600 hours over the preceding three years).

Practice hours in 20\_\_\_\_:  20\_\_\_\_:  20\_\_\_\_:

Indicate specific number of hours, e.g. 500.

**Note:** Acceptable continuous practice activities include the provision of clinical dental treatment, employment as a dental educator, or full-time enrollment in a dental education program.

**Continuing Education**

Please attach a copy of your current continuing education transcript from any **other** regulatory/licensing body if applicable indicating that you have met the requirements of that body (defined as 36 credits over the preceding three years).

### 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 necessary). Information provided is **confidential** to CDSBC.

If you are unclear or unsure about how to respond to any of these questions, please contact staff for clarification.

Do you have a medical 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
While attending at a post-secondary institution, have allegations of misconduct, including academic misconduct, ever been made against you?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever been suspended, required to withdraw, expelled or penalized by a post-secondary institution for any type of misconduct?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you currently charged with a criminal or other offence in Canada or elsewhere?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever been convicted of a criminal or other offence in Canada or elsewhere?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever been the subject of complaints in relation to your practice of dentistry or any other profession with the registration/licensing authority?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has any regulatory action been taken against you as a result of any complaint, investigation or disciplinary proceeding?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
At the present time, are there any investigations, reviews or proceedings taking place in any jurisdiction concerning your practice of dentistry or any other profession?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever been found guilty of professional misconduct or incompetence in any jurisdiction?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has your registration as a dental healthcare provider or any other profession ever been suspended, revoked or restricted in any way?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever voluntarily surrendered your licence/registration as a professional in another jurisdiction?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever been denied registration/licensure by any health profession regulator in any jurisdiction?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever practised as a Certified Dental Assistant or other professional without a license/registration?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

### Authorization and Oath

- I am applying to be certified as a practising certified dental assistant with the College of Dental Surgeons of British Columbia (“CDSBC”) pursuant to the Bylaws made under the *Health Professions Act* (the “HPA”). 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 “Certification-Related Information”), and to then consider and use the Certification-Related Information, all for the purpose of determining my fitness for certification as a practising certified dental assistant in British Columbia.
- I have read and understood CDSBC’s *Standards and Guidance documents*, including the *Code of Ethics*, which facilitate the delivery of competent and ethical patient-centred care. I understand that I am responsible for applying these standards and guidelines in my practice.
- I acknowledge and understand that in order to practise safely, I must be both competent and fit to practise. Competent – in that I have the requisite knowledge, skills and experience. Fit to practise – in that I am not impaired by some physical, mental or addiction issue that affects my ability.
- I recognize that those who, in good faith, furnish Certification-Related Information to CDSBC in connection with my application for certification have reasonable expectations that such Certification-Related Information will be kept confidential.
- I further understand that 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 registration.

**Signature** \_\_\_\_\_

**Date – M/D/Y** \_\_\_\_\_



## STATUTORY DECLARATION (CERTIFIED DENTAL ASSISTANT)

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

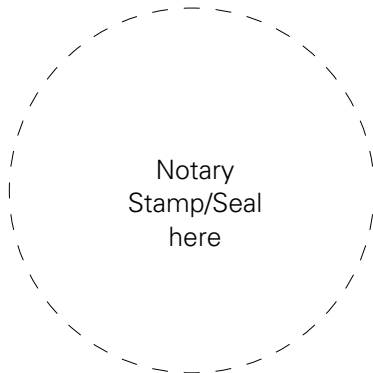
I, \_\_\_\_\_ (name of applicant), declare that the answers given to the questions in this application and the information I supplied on this application, are true, complete, and accurate in every respect, and I make this solemn declaration conscientiously believing it to be true, and knowing that it 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)







## CRIMINAL RECORD CHECK AUTHORIZATION

### Applicant Name

\_\_\_\_\_  
Surname First name Middle name

**Other names used or have used** (e.g. maiden name, birth name, previous married name, preferred name)

\_\_\_\_\_  
Surname First name Middle name

\_\_\_\_\_  
Surname First name Middle name

\_\_\_\_\_  
Surname First name Middle name

**B.C. Driver's Licence # (if applicable)** \_\_\_\_\_

### 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 of 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.

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

**Applicant Signature** \_\_\_\_\_ **Date – M/D/Y** \_\_\_\_\_

The information requested on this form is collected under the authority of the *Criminal Records Review Act* section 4(1) and section 26(c) of the **Freedom of Information and Protection of Privacy Act (FOIPPA)**. The information provided will be used to fulfil the requirements of the *Criminal Records Review Act* for the release of criminal records information and is in compliance with the *FOIPPA*.

MAKE SURE YOU HAVE SIGNED THIS FORM.



## 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.