500 – 1765 West 8th Avenue
Vancouver BC Canada V6J 5C6

Phone 604 736 3621
Toll Free 1 800 663 9169
www.cdsbc.org

CDSBC | College of Dental Surgeons of British Columbia

CERTIFIED DENTAL ASSISTANT INSTRUCTIONS FOR APPLICATION FOR TRANSFER – NON-PRACTISING TO PRACTISING

This application package is for Non-practising Certified Dental Assistants who have held Non-practising certification status for no more than three years and have met the following Quality Assurance (QA) Requirements:

- a minimum of 600 hours of continuous practice* in the preceding three years, and
- prior to transfer, fulfilled the CDSBC Continuing Education Requirements as though the CDA has been a practising CDA for the period since the CDA last held practising certification.

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

Note – Supporting documentation of continuous practice is not required, but may be requested.

If it is over three years since holding Practising CDA Certification, or you do not meet the QA requirements, please contact CDSBC for further information.

Contents

- Application for Transfer from Non-Practising to Practising Certified Dental Assistant
- Applicant Credit Card Authorization Form

Practising CDA Fees

If certification is finalized between 1 March – 31 August _____ C$57

If certification is finalized between 1 September – 28 February _____ C$33

Fees may be paid:

- By credit card – Applicant Credit Card Authorization Form must be completed
- By attaching a cheque or money order payable to CDSBC
- By cash or Interac – only if paid in person at the CDSBC office Monday – Friday from 8:00 am to 4:30 pm.

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 the questions on the application form?
- ☐ If licensed in another jurisdiction, have you:
  - – requested a Letter of Standing from that licensing or regulatory authority?
- ☐ Have you signed your application?
- ☐ Have you enclosed payment?

Please note all incomplete applications will be returned.

CDSBC College of Dental Surgeons of British Columbia

CERTIFIED DENTAL ASSISTANT – APPLICATION FOR TRANSFER FROM NON-PRACTISING TO PRACTISING

Surname _____

Previous Surname (if applicable) _____

First _____ **Middle** _____

Preferred Name _____

Date of birth – M/D/Y _____ **Gender** ☐ female ☐ male

Place of birth – City/Province/Country _____

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 _____

Personal Email (for confidential information from CDSBC) _____

Practice

Address _____ Phone _____

City _____ Province _____

Postal Code _____ Email _____

Privacy and Security

CDSBC must collect and manage certain personal information to fulfill its regulatory purpose as set out in the *Health Professions Act*. 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 consent level for release of information.

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 to be released to selected 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.
- This does not include commercial enterprises providing products or services.

Are you licensed or certified elsewhere as a healthcare provider?

☐ Yes ☐ No If yes, complete the following:

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

Are you practising elsewhere as a healthcare provider?

☐ Yes ☐ No If yes, an original letter or certificate of standing must be sent directly to CDSBC from that regulatory/licensing organization.

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, indicate specific number of hours, e.g. 650.

Practice hours in 20____: ☐ 20____: ☐ 20____: ☐

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.

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*. 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 sole purpose of determining my fitness for certification as a practising certified dental assistant in British Columbia.
- I have read CDSBC's *Code of Ethics* and *Standards of Practice for Dentists and Certified Dental Assistants* and understand that they apply to me.
- I recognize that in order to practise I must not only possess current skills and knowledge but also that I need to be in good physical and mental health. I am aware that CDSBC and the BCDA have support programs and recovery pathways for me which will allow for safe return-to-practice should I suffer from an addiction/dependency disease. I acknowledge that should I be medically or physically unfit, my duty to the safety of my patients and my legal/ethical obligations to my profession require that I immediately cease practice and notify CDSBC in strictest confidence. CDSBC will work with me to seek treatment and a pathway back to safe practice. Further information on this is available at www.cdsbc.org.
- 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 certification.

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

MAKE SURE YOU HAVE SIGNED THIS FORM.

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APPLICANT CREDIT CARD AUTHORIZATION FORM

Applicant name: _____

☐ VISA ☐ Mastercard

Card number: _____ **Expiry:** _____

Choose one of the following certification fees:

☐ C$57 (If finalized between 1 March – 31 August)

☐ C$33 (Half-year pro-ration if finalized between 1 September – 28 February)

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.