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

DENTIST – LIMITED REGISTRATIONS
REINSTATEMENT OF LAPSED REGISTRATION INSTRUCTIONS

This application package is for dentists who have lapsed registration over 60 days and wish to reinstate their registration with CDSBC. **Note: If your registration has been lapsed less than 60 days please reinstate using the current online renewal process at www.cdsbc.org.**

Contents

- Form 15: Reinstatement of Lapsed Registration Application
- Form 2: Statutory Declaration
- Quality Assurance Form
- Applicant Credit Card Authorization Form
- Commissioner for Oaths Information Sheet
- Criminal Record Check Authorization

Reinstatement and Registration Fees

Reinstatement Fee ______ C$0

Registration Fee for March 1, 2015 to February 29, 2016 (non-refundable after registration is granted)

- Limited (education) ______ C$750
- Limited (research) ______ C$78
- Limited (volunteer) ______ C$0
- Limited (armed services) ______ C$750
- Limited (post-graduate) ______ C$300

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.

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

Please note all incomplete applications will be returned.

Checklist

- ☐ Have you answered all questions on the reinstatement form?
- ☐ Have you attached a passport-sized head and shoulder photograph to your application?

  Note: – photo must be attached to application prior to notorization
  – photocopied photos are not accepted
- ☐ Have you enclosed a copy of name change documents if your name has changed?
- ☐ Have you signed your application form and had it, the Statutory Declaration and the government issued photo identification notarized by a Commissioner for Oaths who has applied a stamp or seal?
- ☐ Have you enclosed separate payments for the reinstatement and registration fees?
- ☐ Have you completed and enclosed the Criminal Record Check (CRC) form and included the payment?
- ☐ A notarized copy of government issued photo identification (driver's license is preferred) that displays your name, date of birth and signature is mandatory for the CRC. Have you enclosed this?
- ☐ Have you applied for your malpractice insurance?
- ☐ If licensed or previously licensed in another jurisdiction, have you:
  - requested a Letter or Certificate of Standing from that licensing or regulatory authority?
  - submitted a completed Quality Assurance Form?

Attach a passport sized photo taken within the past 12 months

Photo must be attached prior to notarization

Notary Stamp/Seal here

DENTIST REINSTATEMENT OF LAPSED REGISTRATION

Registration Category – Select ONE only

☐ **Limited (post-graduate)**
☐ **Limited (armed services)**
☐ **Limited (education)**
☐ **Limited (volunteer)**
☐ **Limited (research)**

Surname ____________________

Previous Surname (if applicable) ____________________

First ____________________

Middle ____________________

CDSBC Registration Number __________ **Date of birth** – M/D/Y __________

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) __________

The *Health Professions Act* requires that all registrants provide a business address and phone number. If you do not provide practice contact information, your home contact information will be published in the *Directory of Dentists.*

Practice – Practice office is published in the *Directory of Dentists*

Address __________ Phone __________

City __________ Fax __________

Province __________ Postal Code __________ Email __________

☐ Include email in *Directory of Dentists*

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) __________

I wish to receive mail from CDSBC (check one only) ☐ at my practice address ☐ at my home address

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

Privacy and Security

The information you provide here relates to the operations of CDSBC under the *Health Professions Act*. 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 may 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)**

- Includes **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)**

- Includes **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.
- This does not include commercial enterprises providing products or services.

Dental Education

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

Do you have a National Dental Examining Board (NDEB) certificate? ☐ Yes ☐ No

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).

Have you been or are you licensed or certified elsewhere as a dental healthcare provider?
☐ Yes ☐ No If yes, please provide details.

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

Have you ever applied for registration/licensure as a dental healthcare provider in another jurisdiction and been denied? ☐ Yes ☐ No If yes, please provide details. (use separate sheet)

Provide original letters or certificates of standing from all licensing jurisdictions where you have been or are licensed/registered/certified as a dental healthcare provider, 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 ______________________

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.

While attending at a post-secondary institution, have allegations of misconduct, including academic misconduct, ever been made against you or have you ever been suspended, required to withdraw, expelled or penalized by a post-secondary institution for misconduct? ☐ 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 reinstate my registration 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 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 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 ______________________________

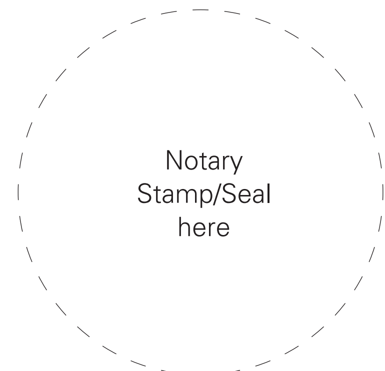
DECLARED before me at the city of ______________ , in (country) ______________ ,

this ________ day of ______________ , 20___ .

A Commissioner for Oaths or Notary Public

____

Must include a stamp or seal of Commissioner for Oaths or Notary Public on page 1 of the application (where indicated), on this page and on Form 2 Statutory Declaration.



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APPLICATION MUST BE COMPLETE, WITH PHOTO ATTACHED, PRIOR TO NOTARIZATION.

FORM 2

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.

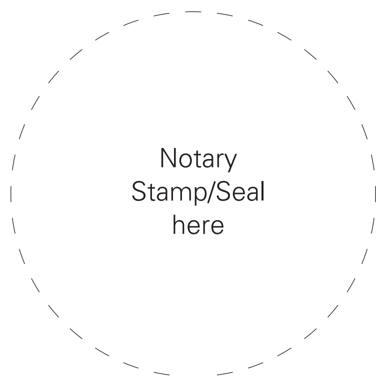
Signature of Applicant ____

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)



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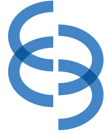

CDSBC | College of Dental Surgeons of British Columbia

QUALITY ASSURANCE FORM

Continuous Practice

Please provide details of continuous practice (defined as at least 900 hours over the preceding three years). 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.

Year	Practice Location – City, Prov/State	# of Hours/Year
20 ____		
20 ____		
20 ____		
20 ____		

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/Year
20 ____	
20 ____	
20 ____	

Name of Applicant: ______________________________

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

MAKE SURE YOU HAVE SIGNED THIS FORM.

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Vancouver BC Canada V6J 5C6
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APPLICANT CREDIT CARD AUTHORIZATION FORM

Applicant name: ______________________________

☐ VISA ☐ Mastercard

Card number: ______________________________ **Expiry:** ______________

Please indicate your approval for your credit card to be charged for each of the following:

Registration fee:

☐ C$750 Limited (education) Registration

☐ C$750 Limited (armed services or government) Registration

☐ C$78 Limited (research) Registration

☐ C$300 Limited (post-graduate) Registration

Cardholder's name (please print): ______________________________

Cardholder's signature: ______________________________

Payment by phone is not available. Your signature is required to authorize payment.

MAKE SURE YOU HAVE SIGNED THIS FORM.

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Vancouver BC Canada V6J 5C6
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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.

BRITISH COLUMBIA | Ministry of Justice

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 a payment of $28 is included with the form. Note: no cash or personal cheques are accepted. Providing your Driver's Licence Number may expedite the process.

Schedule Type (choose one): ☐ A ☒ B ☐ C ☐ D ☐ E

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:

Legal Surname / Last name:	Legal Given / First Name:	Legal Middle Name:

DATE OF BIRTH: ______ YYYY MM DD GENDER: ☐ M ☐ F BIRTHPLACE: ______

ADDITIONAL NAMES (Alias, Maiden Name, etc.):

Surname / Last name:	Given / First Name:	Middle Name:

Mailing Address:	City:	Country:	Province:	Postal Code:

Contact phone no. ( )	Driver's Licence #:

PART 2: ORGANIZATION INFORMATION:

SECTION A Complete this section if you have been provided with an ID number by the Criminal Records Review Program.

Organization Name: College of Dental Surgeons of BC

Organization Contact Name or Title (The person receiving the result of the check): CDSBC Registration Department	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:ÁÞŒ

Mailing Address:ÁÞŒ

City:ÁÞŒ	Province:ÁÞŒ	Country:ÁÞŒ	Postal Code:ÁÞŒ

Office Phone: NA	Fax:ÁÞŒ

Applicant's Position / Job Title with Organization: NA	• Organization type MUST be selected • ID MUST be verified

Organization Type: ☐ Health Authority ☐ Community Living BC ☐ Licensed Child Care Facility ☐ Unlicensed Child Care Facility ☐ Licensed Adult Care Facility ☐ School District ☐ Independent/Private School ☐ University ☐ College ☐ Ministry ☐ Contractor ☐ Government Agency ☒ Other Dental Regulatory Body

PART 3: SCHEDULE D ONLY MUST PROVIDE:

Licensed Child Care or Adult Care Facility Name: NA

CONSENT FOR RELEASE OF INFORMATION AND ACKNOWLEDGMENTS

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 YYYY / MM / DD

Visit the Criminal Records Review Program online at:
www.pssg.gov.bc.ca/criminal-records-review
Email: sgspdps@gov.bc.ca

Ministry of Justice
Criminal Records Review Program
Policing and Security Programs Branch, Security Programs Division
PO Box 9217 Stn Prov Govt, Victoria BC V8W 9J1
Phone: toll-free 1-855-587-0185 Fax: (250) 356-1889

Consent to a Criminal Record Check (Schedule A, B, C, D, or E)

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 listed in schedule 2 of the Criminal Records Review Act, or b) is a registered student in a post secondary program with a practicum component involving work with children and / or vulnerable adults. The requesting organization 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 the 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 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 at a child care or adult care (vulnerable adults) facility, licensed under the Community Care and Assisted Living Act. The manager or owner / operator of the facility retains the original signed consent form.

CHECKLIST for Applicant

- ☐ I understand which 'schedule type' and which 'works with' category pertains to me (if this is not clear, please ask your organization).
- ☐ I have completed the applicable sections of the form truthfully, clearly and legibly, and signed and dated it.
- ☐ I have read and understand the Consent for Release of Information and Acknowledgements and information regarding the Freedom of Information and Privacy Act (FOIPPA).
- ☐ My organization has verified my ID in person to confirm my identity and information on the consent form is accurate.
- ☐ My payment of $28 is attached. See the website for acceptable payment methods.
- ☐ 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.

CHECKLIST for Organization

- ☐ The employee/applicant will provide you with the original, completed and signed consent form.
- ☐ Verify the ID of each employee/applicant in person to confirm identity and ensure the information matches that provided on the consent form. Note: Please use Canadian Driver License if applicant has one.
- ☐ Retain the original form(s).
- ☐ Forward a copy of the form(s), along with payment, to the Criminal Records Review Program by mail or fax:
  - MAIL: Criminal Records Review, Ministry of Justice, PO Box 9217 Stn Prov Govt, Victoria BC V8W 9J1
  - FAX the credit card authorization form, available at: www.pssg.gov.bc.ca/criminal-records-review/shareddocs/creditcard.pdf with the completed consent 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 charges and 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 consent to a check of all available law enforcement systems, including any local police records.
  - I hereby consent to a vulnerable sector search to check if I have been convicted of and been granted a pardon for any sexual offences of the Criminal Records Act.
  - I understand a criminal record check under the criminal records review act is required at least once every five years.
  - Go to the RCMP website for additional details on vulnerable sector checks: www.rcmp-grc.gc.ca/cr-cj/vulner/index-eng.htm
- 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 t or any police investigations deemed relevant by the Registrar.
- 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.

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. If you have questions about the collection of your personal information, please contact the Policy Analyst, Criminal Records Review Program, PO Box 9217 Stn Prov Govt, Victoria, BC V8W 9J1 or by phone at (250) 387-2896.

BRITISH COLUMBIA | Ministry of Justice

APPLICATION FOR PRE-AUTHORIZED CREDIT CARD USAGE

Criminal Records Review Program

TO BE COMPLETED IF PAYING BY CREDIT CARD

Directions: You may complete the form fields at your computer, print, then sign and date it. OR you may print the form out and complete it 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 emailed**.Mail or fax this form to the Criminal Records Review Program (address below).

PART A – 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 B – FOR SECURITY PROGRAMS USE ONLY:

Bundle #: ____________________ Completed by: ____________________

PART C – 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 $28.00 for each applicant listed in Part A: $ _______ (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: ______ / ______ / _____ (Month / Day / Year)

Mailing Address:			City:
Country:	Province:	Postal Code:	Contact phone no. ( )
Name of Organization: College of Dental Surgeons of BC			

Visit the Criminal Records Review Program online at:
www.pssg.gov.bc.ca/criminal-records-review
Email: sgspdps@gov.bc.ca

CRR012 / 2013-11-21

Ministry of Justice
Criminal Records Review Program
Policing and Security Programs Branch, Security Programs Division
PO Box 9217 Stn Prov Govt, Victoria BC V8W 9J1
Phone: toll-free 1-855-587-0185 Fax: (250) 356-1889