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

Phone 604 736 3621
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www.cdsbc.org

CDSBC | College of Dental Surgeons of British Columbia

DENTIST
INSTRUCTIONS FOR APPLICATION FOR TRANSFER

This application package is for dentists who ***hold current registration*** with CDSBC and wish to transfer to another class of registration.

All registration requirements of the requested registration class must be met and confirmed by supporting documentation. Quality Assurance Requirements (continuing education and continuous practice) must be met.

Documentation

In addition to a completed Application for Transfer, the following supporting documentation is required if not currently on file with CDSBC. Please email registration@cdsbc.org for confirmation:

For Full Registration:

- Copy of NDEB Certificate
- Verification of current liability insurance

For Academic Registration:

- Written verification of full-time appointment as a full professor, associate professor or assistant professor of dentistry at UBC or another post-secondary educational institution
- Verification of current liability insurance

For Limited (education, research or volunteer) Registration:

- Copy of NDEB Certificate
- Written verification of purpose for registration e.g. presenting a dental course, conducting or engaging in a clinical presentation, study club, research program or dental teaching program at or under the sponsorship of the Faculty of Dentistry at UBC, another post-secondary institution or other group or organization approved by the CDSBC Registration Committee, or for the purpose of carrying out volunteer activities
- Verification of current liability insurance

For Limited (armed services or government) Registration:

- Written verification of the registrant's employment with or by the Canadian Armed Services or government

For Limited (post-graduate) Registration:

- Written verification that the registrant is taking or engaging in a course, clinical placement, research program, internship or residency offered at the post-graduate level by or under the sponsorship of the Faculty of Dentistry at UBC or another post-secondary educational institution, hospital or other institution approved by the CDSBC Registration Committee

Please note all incomplete applications will be returned.

FEES

Initial application and annual registration fees already paid for 2017/18 will be applied to the new registration class. Any outstanding balance 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.

Annual registration fees are non-refundable once paid, regardless of registration class.

Current registration	**Application Fee 2018/19**		**Registration Fee 2018/19**		
	Paid for current registration	**To transfer to Full Registration**	***Paid for current registration***	**To transfer to Full Registration** Mar. – Aug.	**To transfer to Full Registration** Sept. – Feb.
Academic	*C$2,790*	C$0	*C$3,078 (or pro-rated Sept. – Feb. C$1,539)*	C$0	C$0
Limited (education)	*C$698*	C$2,092	*C$698*	C$2,380	C$841
Limited (research)	*C$73*	C$2,717	*C$73*	C$3,005	C$1,466
Limited (volunteer)	*C$73*	C$2,717	*C$0*	C$3,078	C$1,539
Limited (armed services or government)	*C$698*	C$2,092	*C$698*	C$2,380	C$841
Limited (post-graduate)	*C$73*	C$2,717	*C$279*	C$2,799	C$1,260
Non-practising	*C$2,790*	C$0	*C$698*	C$2,380	C$841

* Please contact CDSBC for confirmation of fees payable.

Please submit all completed forms, documents and fee to:

College of Dental Surgeons of BC
500 – 1765 West 8th Avenue
Vancouver, BC V6J 5C6

CDSBC College of Dental Surgeons of British Columbia

DENTIST – APPLICATION FOR TRANSFER

Surname _____ **First** _____

Middle _____ **Preferred Name** _____

Previous Surname (if applicable) _____

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

Current Registration Class – indicate ☒

- ☐ Full
- ☐ Certified Specialist
- ☐ Restricted to Specialty
- ☐ Academic or Academic grandparented
- ☐ Limited (education)
- ☐ Limited (research)
- ☐ Limited (volunteer)
- ☐ Limited (armed services or government)
- ☐ Limited (post graduate)
- ☐ Non-Practising

Registration requested – indicate ☒

- ☐ Full
- ☐ Certified Specialist
- ☐ Restricted to Specialty
- ☐ Academic
- ☐ Limited (education)
- ☐ Limited (research)
- ☐ Limited (volunteer)
- ☐ Limited (armed services or government)
- ☐ Limited (post graduate)
- ☐ Non-Practising

Requested Effective date of transfer _____

If holding or transferring to non-practising registration:

☐ As a non-practising dentist, I declare that I will not practise dentistry in B.C. without first converting my registration to practising status. Initial here _____

The *Health Professions Act* requires that all registrants provide a business address and phone number. If you do not have practice contact information, you must include a *phone number and *email address that will be published in the *Registrant Lookup.*

Practice – Submit any satellite office address(es) on a separate sheet
Practice and satellite offices are published in the *Registrant Lookup*
One practice address must be made available to the public

Address _____ *Phone _____

City _____ Province _____

Postal Code _____ *E-mail _____

☐ Include email in *Registrant Lookup*

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

Address _____ Phone _____

City _____ Province _____

Postal Code _____ Cell _____

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

Quality Assurance Requirements

If your NDEB Certificate was issued more than three years ago, have you engaged in the practise of dentistry in another jurisdiction over the preceding three years? ☐ Yes ☐ No

Continuous Practice Hours

Practice hours in 20___: ☐ 20___: ☐ 20___: ☐

Indicate specific number of hours, e.g. 950.
Note: 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.

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:on.

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 practice address, telephone number, and email address (if requested);
- The year of your graduation, and the year of your initial registration with CDSBC;
- The class of registration held, and any limits or conditions imposed on your registration, including any notations of cancellation or suspension of your registration; and
- Additional CDSBC registered qualifications, such as for sedation.

☐ **Level 2**

This consent level, in addition to **Level 1**, allows for personal contact information (mailing address) to only 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**

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 or about individual CDSBC election campaigns.
- This does not include commercial enterprises providing products or services.

Are you registered/licensed elsewhere as a healthcare provider?

☐ Yes ☐ No If yes, complete the following:

Jurisdiction	City/Country	Time Period 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.

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

Malpractice Insurance

Select applicable box. Coverage of at least $3,000,000 for British Columbia is mandatory.

☐ CDSPI ☐ Other _____

Note: if you already have liability insurance in another jurisdiction, please confirm that the coverage extends to B.C. You will need to provide a copy of your policy if so.

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.

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)	☐ Yes	☐ No
While attending at a post-secondary institution, have allegations of misconduct, including academic misconduct, ever been made against you?	☐ Yes	☐ No
Have you ever been suspended, required to withdraw, expelled or penalized by a post-secondary institution for any type of misconduct?	☐ Yes	☐ No
Are you currently charged with a criminal or other office in Canada or elsewhere?	☐ Yes	☐ No
Have you ever been convicted of a criminal or other offence in Canada or elsewhere?	☐ Yes	☐ No
Has any complaint or disciplinary action been taken against you by any licensing authority for dentistry or any other profession?	☐ Yes	☐ 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?	☐ Yes	☐ No
Have you ever been found guilty of professional misconduct or incompetence in any jurisdiction?	☐ Yes	☐ No
Has your registration in dentistry or any other profession ever been suspended, revoked or restricted in any way?	☐ Yes	☐ No
Have you ever voluntarily surrendered your licence/registration as a professional in another jurisdiction?	☐ Yes	☐ No
Have you ever practised as a dentist or other professional without a licence/registration?	☐ Yes	☐ No
Have you ever been denied registration/licensure by any health profession regulator in any jurisdiction?	☐ Yes	☐ No

Authorization and Oath

- I am applying to register 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 _____ **Date** – M/D/Y _____

Your transfer cannot be completed without your signature.

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APPLICANT CREDIT CARD AUTHORIZATION FORM

Applicant name: _____

☐ VISA ☐ Mastercard

Card number: _____ **Expiry:** _____

Application fee:

C$_____

Registration fee:

C$_____

Cardholder's name (please print): _____

Cardholder's signature: _____

By signing this form you are authorizing both fees.

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

MAKE SURE YOU HAVE SIGNED THIS FORM.