MANITOBA DENTAL ASSOCIATION
202-1735 Corydon Avenue, Winnipeg, MB, r3n 0k4
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DENTAL ASSISTANT CHANGE OF STATUS APPLICATION

IDENTIFY CHANGES REQUESTING:

- ☐ CHANGE FROM PROVISIONAL TO FULL REGISTRATION
- ☐ CHANGE FROM FULL REGISTRATION TO NON-PRACTISING
- ☐ CHANGE FROM NON-PRACTISING TO FULL REGISTRATION
- ☐ REGISTRATION FOR ORTHODONTIC EXPANDED PRACTICE
- ☐ REGISTRATION FOR SCALING EXPANDED PRACTICE

PERSONAL AND EDUCATION

NAME

_____ _____
SURNAME GIVEN NAMES (PLACE ASTERIK BESIDE PREFERENCE)

Is your name now different from the one on your diploma/certificate/degree? ☐ YES ☐ NO
If "yes" please provide a certified copy of a *legal document certifying name change* (i.e. Marriage Certificate, Legal Name Change Decree, etc.)

IDENTIFICATION

Please provide a *certified copy of your birth certificate, citizenship card or proof of permanent residency status*.
Please provide details of your current citizenship and a *certified copy of the authorization issued by Citizen and Immigration Canada* which permits you to engage in the practice of dentistry in Canada.

PRACTICE ADDRESS

_____
SUITE STREET CITY PROVINCE POSTAL CODE

_____
TELEPHONE FAX EMAIL

Submit any satellite office addresses on a separate sheet.
Your home practice contact information will be published in the public registry if you do not provide practice information.

HOME ADDRESS

_____
SUITE STREET CITY PROVINCE POSTAL CODE

_____
TELEPHONE CELLULAR TELEPHONE EMAIL

NDAEB CERTIFICATE

Do you have a National Dental Assisting Examining Board Certificate? ☐ YES ☐ NO

If "yes" please provide_____, _____ and a *certified copy of your NDAEB Certificate*.
CERTIFICATE NUMBER DATE (MM/YYYY)

Has there been a period of three years or more since obtaining your NDAEB Certificate when you did not practice on a continuous and regular basis in Canada or the United States of America? ☐ YES ☐ NO

EXPANDED PRACTICE MODULES

Indicate which if any expanded practice modules completed at an accredited dental training programme.

MODULE	EDUCATIONAL INSTIRUTION	DATE STARTED MM/YYYY	DATE COMPLETED MM/YYYY
☐ ORTHODONTIC ASSISTING			
☐ SCALING MODULE			

Include a *certified copy of your module certificate* for each successfully completed training programme.

CPR TRAINING

Have you provided the MDA a current valid CPR certificate? ☐ YES ☐ NO

If "no", include a *copy of document from CPR programme* evidencing successful completion and validation date.

HEALTH AND CONDUCT

FOR RESPONSE

Please attach a separate sheet *with written details for any of the following questions that answer in the affirmative* ("yes").

HEALTH AND HEALTH HISTORY

Do you currently have a physical, mental or addiction disorder or condition which may impair your ability to practise dental assisting safely and competently, or if left untreated, would impair your ability? ☐ YES ☐ NO

Have you at any time in the previous ten years suffered from a physical, mental or addiction disorder or condition which has or had impaired your ability to practise safely, or if left untreated, would have impaired your ability? ☐ YES ☐ NO

Include in your written details names and addresses of healthcare practitioners who have treated you for your disorder or condition. Please complete and provide *Consent to Release Health Information forms for each healthcare provider* to MDA.

CONTINUITY OF PRACTICE

Has there been a period of three years or more since obtaining your degree from a dental training programme when you did not practice dentistry on a continuous and regular basis in Canada, United States, Australia, New Zealand or Republic of Ireland? ☐ YES ☐ NO

Include in your written details a description of reason and activities during time period not practising dentistry.

REGULATORY CONDUCT

Are there any current investigations, review, proceedings or appeals in any jurisdiction that could result in restrictions, conditions or limitations being placed on your ability to practise a health profession or suspension or cancellation of your entitlement to practise a health profession? ☐ YES ☐ NO

Have you at any time been subject to a finding of professional misconduct, conduct unbecoming or incompetence related to the practice of a health profession in any jurisdiction? ☐ YES ☐ NO

Do you have any current or had previous restrictions, conditions or restrictions on your entitlement to practise any health profession in any jurisdiction? ☐ YES ☐ NO

Have you ever voluntarily surrendered your license/registration to practise a health profession? ☐ YES ☐ NO

JUDICIAL CONDUCT

Have you ever been found guilty of a criminal offence, either in Canada or in any other jurisdiction? This includes a finding of guilt under the *Criminal Code of Canada*, the *Controlled Drugs and Substances Act* (Canada) formerly the *Narcotics Control Act* (Canada) and the Food and Drug Act (Canada) or any other offence where the penalty could have resulted in your being incarcerated? ☐ YES ☐ NO

Are criminal charges pending or outstanding against you in any jurisdiction? ☐ YES ☐ NO

Have you at any time been the subject of a finding or negligence, professional malpractice or civil fraud in any jurisdiction? ☐ YES ☐ NO

STATUTORY REVIEW

Are you listed on any child abuse registry in any jurisdiction? ☐ YES ☐ NO

Are you listed on any adult abuse registry in any jurisdiction? ☐ YES ☐ NO

DECLARATION

I solemnly declare that the contents of this application are true and complete to the best of my knowledge and belief.

I understand and agree that if I make a false or misleading statement or representation in respect of my application, I shall be deemed not to have satisfied the requirements for registration and licensure. I further understand and agree that if registration and a licence should be issued to me based upon a false or misleading statement or representation that said registration and licence are subject to immediate cancellation.

Taken and declared before me in the District, Province or State of _____

this _____ day of _____, 20_____.

_____ _____

Signature of Applicant Signature of Witness