



**MANITOBA DENTAL ASSOCIATION**

202-1735 Corydon Avenue, Winnipeg, MB, R3N 0K4  
T: 204.988.5300 F: 204.988.5310 www.manitobadentist.ca

Please attach a passport-sized photo taken within the past twelve months

**DENTAL ASSISTANT REINSTATEMENT APPLICATION FORM**

**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 INSTITUTION	DATE STARTED MM/YYYY	DATE COMPLETED MM/YYYY
<input type="checkbox"/> ORTHODONTIC ASSISTING			
<input type="checkbox"/> SCALING MODULE			

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

**PRACTICE INFORMATION**

**HEALTH  
PROFESSION  
REGISTRATION  
AND  
LICENSURE  
HISTORY**

Are you currently registered or licensed to practise any health profession including dental assisting in any jurisdiction including Manitoba?  YES  NO

Have you been previously registered or licensed to practise any health profession including dental assisting in any jurisdiction including Manitoba?  YES  NO

If “yes” to either question, indicate details for every governing body in the following table. Attach a separate list if required. Please request the *indicated governing bodies complete our Certificate of Standing form* and submit have them submit it directly to the MDA. Please complete and provide *Consent to Release forms for each governing body* to the MDA.

JURISDICTION PROV/STATE/COUNTRY	GOVERNING BODY	TYPE OF LICENSE	REGISTRATION START DATE	REGISTRATION END DATE

Have you ever been refused registration or licensure to practise any health profession including dentistry in any jurisdiction including Manitoba?  YES  NO

If “yes” please provide details in the following table. Attach a separate sheet if required. Please provide a *copy of the governing body’s written decision and reasons* and provide *Consent to Release forms for each governing body* to the MDA.

JURISDICTION	GOVERNING BODY	TYPE OF LICENSE DENIED

**MEDICAL  
EMERGENCY  
TRAINING**

Have you successfully completed a resuscitation/life support programme approved by the MDA?  YES  NO

If “yes”, please provide details in the following table.

PROGRAMME NAME AND ADDRESS	CERTIFICATE DATE DD/MM/YYYY	VALID UNTIL DD/MM/YYYY

Include a *certified copy of official documentation from 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 of 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

