**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

## DENTIST INITIAL REGISTRATION APPLICATION FORM

**REGISTRATION TYPE (SELECT ONLY ONE)**

- ☐ GENERAL PRACTITIONER
- ☐ DENTAL SPECIALIST IN _____
- ☐ ACADEMIC
- ☐ STUDENT
- ☐ CHARITABLE PURPOSE
- ☐ DENTAL EDUCATOR
- ☐ CONTINUING EDUCATION COURSE PARTICIPANT
- ☐ NON-PRACTISING

**PERSONAL**

**NAME**

_____
SURNAME GIVEN NAMES (PLACE ASTERIK BESIDE PREFERENCE)

Is your name now different from the one on your 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.)

**BIRTHDAY**

_____
DAY MONTH YEAR

**CITIZENSHIP**

_____
COUNTRY OR COUNTRIES

Are you a Canadian citizen or permanent resident of Canada? ☐ YES ☐ NO

**IDENTIFICATION**

If "yes" please provide a *certified copy of your birth certificate, citizenship card or proof of permanent residency status*.
If "no" 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.

**FLUENCY**

☐ ENGLISH ☐ FRENCH ☐ OTHERS_____
SPECIFY LANGUAGE(S)
Submit additional languages on a separate sheet if insufficient space.

**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

## EDUCATION

### GRADUATE OF DENTAL TRAINING PROGRAMME

| UNIVERSITY AND LOCATION | DIPLOMA/DEGREE | DATE STARTED MM/YYYY | DATE COMPLETED MM/YYYY |
|---|---|---|---|
| | | | |
| | | | |

Include *original letter from the Dean* or his/her designate and a *certified copy of your graduation degree* for each dental training programme.

### NDEB CERTIFICATE

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

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

If "no" are you applying using labour mobility legislation? ☐ YES ☐ NO

Has there been a period of three years or more since obtaining your NDEB Certificate 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

### GRADUATE OF DENTAL INTERNSHIP OR SPECIALTY TRAINING PROGRAMME

| UNIVERSITY AND LOCATION | DIPLOMA/DEGREE | DATE STARTED MM/YYYY | DATE COMPLETED MM/YYYY |
|---|---|---|---|
| | | | |
| | | | |

Include *original letter from the Dean* or his/her designate and a *certified copy of your graduation degree* for each dental specialty training programme.

### NDSE CERTIFICATE

Do you have a National Dental Specialty Examination Certificate or Fellowship from the Royal College of Canada? ☐ YES ☐ NO

If "yes" please provide a *certified copy of your NDSE Certificate* or *Fellowship from the Royal College of Canada*

If "no" are you applying using labour mobility legislation? ☐ YES ☐ NO

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

### STUDENT OF INTERNSHIP OR SPECIALTY PROGRAMME

Are you enrolled in a hospital based internship programme affiliated with the University of Manitoba? ☐ YES ☐ NO

If "yes" please provide an *original copy of Hospital Internship Agreement*.

Are you enrolled in an accredited dental specialty training programme at the University of Manitoba? ☐ YES ☐ NO

If "yes" please provide an *original letter from the Dean or his/her designate confirming your enrolment* and indicate programme: ☐ ORAL MAXILLOFACIAL SURGERY ☐ ORTHODONTICS ☐ PAEDIATRIC DENTISTRY ☐ PERIODONTICS

Students interested in independent prescribing privileges must apply to the Registrar and meet requirements for placement on that Roster.

### ACADEMIC APPOINTMENT

Do you have a full time appointment at the University of Manitoba - Faculty of Dentistry? ☐ YES ☐ NO

If "yes" please provide an original *letter from the Dean or his/her designate confirming your appointment* and indicate your affiliated programme: ☐GENERAL ☐ ENDO ☐ OMS ☐ OM/OP ☐ ORTHO ☐ PAEDO ☐ PERIO ☐ PROSTHO ☐ PH ☐ RAD

### DENTAL EDUCATOR

Are you planning to provide an educational programme involving the practice of dentistry in association with an approved sponsor? ☐ YES ☐ NO

If "yes", please provide a *certified copy of the sponsor agreement*.

## PRACTICE INFORMATION

### HEALTH PROFESSION REGISTRATION AND LICENSURE HISTORY

**Are you currently registered or licensed to practise any health profession including dentistry in any jurisdiction including Manitoba? ☐ YES ☐ NO**

**Have you been previously registered or licensed to practise any health profession including dentistry 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* have them submit it directly to the MDA. Please complete and provide *Consent to Release Regulatory Information forms for each governing body* to the MDA.**

| JURISDICTION PROV/STATE/COUNTRY | GOVERNING BODY | TYPE OF LICENCE | 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 LICENCE DENIED |
|---|---|---|
| | | |
| | | |

| INFORMATION ON REASONS REGISTRATION OR LICENSE DENIED |
|---|
| |
| |
| |

### CANADIAN JURISPRUDENCE AND ETHICS TRAINING

**Have you successfully completed a Canadian jurisprudence and ethics programme approved by the MDA*? ☐ YES ☐ NO**

**If "yes", please provide a *letter from the programme director* confirming successful completion and dates.**

***MDA approved programmes are listed in SCHEDULE B of the *Bylaw for Registration and Licensure of Dentists*.**

### 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.**

***MDA approved programmes are listed in SCHEDULE C of the *Bylaw for Registration and Licensure of Dentists*.**

## HEALTH AND CONDUCT

**FOR RESPONSES**

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 dentistry 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 dentistry 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 a *Consent to Release Health Information form* for each healthcare provider to MDA.

**CONTINUITY OF PRACTICE**

Has there been a period of three years or more since graduating from a dental training programme when you did not practise 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, including while as a student? ☐ 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 licence/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

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 I

**STATUTORY REVIEW**

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.

**DECLARATION**

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

this _____ day of _____, 20 _____.

NOTARY STAMP/SEAL HERE

_____ A Commissioner for Oaths, Notary Public, Lawyer

_____ Signature of Applicant