



**MANITOBA DENTAL ASSOCIATION**

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

**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

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

**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 \_\_\_\_\_, \_\_\_\_\_ and a *certified copy of your NDEB Certificate*.  
   CERTIFICATE NUMBER                      DATE (MM/YYYY)

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 Royal College of Dentists of Canada National Dental Specialty Examination Certificate?      YES      NO

If “yes” please provide \_\_\_\_\_, \_\_\_\_\_ and a *certified copy of your NDSE Certificate*.  
   CERTIFICATE NUMBER                      DATE (MM/YYYY)

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

**STATUTORY REVIEW**

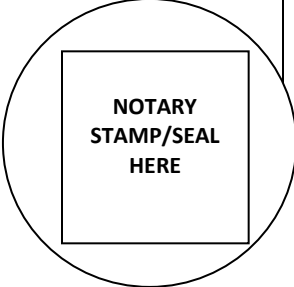
I solemnly declare that the contents of this application are true and complete to the best of my knowledge and belief.

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.

**DECLARATION**

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

this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.



\_\_\_\_\_ A Commissioner for Oaths, Notary Public, Lawyer

\_\_\_\_\_ Signature of Applicant

