Saskatchewan Dental Therapists Association
Internationally Educated Dental Therapists Assessment and GAP Training Program

Program Application

Personal Information

Name*: _____
Last First Middle

Address: _____
Street Address Apt/Unit #

_____
City Prov/State Country Zip/Postal Code

Phone: _____

E-mail: _____

* Proof of name change is required if present name differs from name on last license.

Education Qualification

Training Institute: _____

Address: _____
Street Address Apt./Unit #

_____
City Prov/State Country Zip/Postal Code

Dates: From: _____ To: _____

Date Completed: _____

References

Please list three professional references

Full Name: _____ Occupation: _____

Address: _____ Phone: _____

Email: _____

Full Name: _____ Occupation: _____

Address: _____ Phone: _____

Email: _____

Full Name: _____ Occupation: _____

Address: _____ Phone: _____

Email: _____

Previous Employment

Employer: _____ Phone: _____

Address: _____ Supervisor: _____

Job Title: _____ Hours/wk: _____

Responsibilities: _____

From: _____ To: _____ Reason for leaving: _____

May we contact your previous supervisor for a reference? _____

Employer: _____ Phone: _____

Address: _____ Supervisor: _____

Job Title: _____ Hours/wk: _____

Responsibilities: _____

From: _____ To: _____ Reason for leaving: _____

May we contact your previous supervisor for a reference? _____

Employer: _____ Phone: _____

Address: _____ Supervisor: _____

Job Title: _____ Hours/wk: _____

Responsibilities: _____

From: _____ To: _____ Reason for leaving: _____

May we contact your previous supervisor for a reference? _____

Documentation to be included with application

All documentation is to be submitted to SDTA via email in digital form.

Payment: TBD

Verification and Credential Authentication Report from World Education Services (WES)

- The WES-ICAP course-by-course credential assessment is required.
- The WES-ECA basic report for immigration purposes is not acceptable.
- The assessment report must be sent directly to SDTA from WES.

Verification of Education (copy of certification of graduation)

Training course outlines, syllabus or curriculums from your training program (including clinical hours and practicum hours)

Letter of good standing from applicant's international regulatory authority (to be emailed directly to the SDTA from regulatory body)

Resume or curriculum vitae to include work experience as a dental therapist and employment contact information

Copy of most recent English language test result

Proof of name change if applicable

Declaration

Within the past two years have you been the subject of any investigations, reviews, disciplinary hearings, or proceedings (including criminal proceedings) in any province, territory, state, or country?

Yes No If no please explain.

During the past two calendar years, have you been diagnosed or been treated for drug or alcohol addiction?

Yes No If no please explain.

Within the past two years have you ever been convicted of an offense under the Criminal Code (Canada), the Food and Drug Act (Canada), the Controlled Drugs and Substance Act (Canada) or any other similar legislation in any province, territory, state, or country?

Yes No If no please explain.

Have you been diagnosed with a blood borne communicable disease (including but not limited to Hepatitis B, Hepatitis C, HIV and AIDS) which, by its nature, could place your patients at risk if there were an inadvertent exposure?

Yes No If no please explain.

During the past two calendar years, have you suffered from any mental health condition that may limit your ability to practice or pose a risk of harm to patients?

Yes No If no please explain.

During the past two calendar years, have you suffered from any physical health condition that may limit your ability to practice or pose a risk of harm to patients?

Yes No If no please explain.

Insurance Declaration

In the past, have you ever been the recipient of any allegations of professional negligence in writing or verbally?

Yes No If no please explain.

Are you aware of any facts, circumstances or situations which may reasonably give rise to a claim, other than as advised above?

Yes No If no please explain.

Have you had insurance declined or had a renewal of insurance refused in the past five years?

Yes No If no please explain.

WITHOUT LIMITATION OF ANY OTHER REMEDY AVAILABLE TO THE INSURER, IT IS AGREED THAT IF THERE BE KNOWLEDGE OF ANY SUCH FACT, CIRCUMSTANCE OR SITUATION, ANY CLAIM OR ACTION SUBSEQUENTLY EMANATING THEREFROM IS EXCLUDED FROM COVERAGE UNDER THE PROPOSED INSURANCE.

All members are required to comply with The Dental Disciplines Act and The Saskatchewan Dental Therapists Association Bylaws.

X _____ _____

Signature of Applicant Date

SASKATCHEWAN DENTAL THERAPISTS ASSOCIATION
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