Saskatchewan Dental Therapists Association

Registration Form

I. PERSONAL DATA

Name***:** _____ Nee: _____

Address: _____

_____ (postal code)

Telephone: home or cell: (____) _____ work: (_____) _____

Email: _____

Date of Birth: _____

*****Proof of name change is required if present name differs graduation certificate or transcript of marks.

II. EDUCATION QUALIFICATION

Dental Therapy: School: _____

Address: _____

Dates attended: _____

III. EXPERIENCE

List employers and dates of employment since graduation from Dental Therapy.

Name: _____ Name: _____

Address: _____ Address: _____

_____ _____

Dates of Employment: _____ Dates of Employment: _____

IV. REFERENCES

Name: _____

Address: _____

Occupation: _____ phone: _____

Name: _____

Address: _____

Occupation: _____ phone: _____

Name: _____

Address: _____

Occupation: _____ phone: _____

V. DOCUMENTATION

A) Attach a copy of your certificate of graduation or transcript of marks from graduating school of Dental Therapy.
B) Proof of name change if applicable.
C) If you have not graduated within the past three years, include documentation that you have legally provided dental therapy services for at least 60 days in the last 5-year period.
D) Letter of good standing from your most recent dental therapy employer and regulating authority if applicable.
E) Documents relating to your continuing education activities for the last three years.

VI. DECLARATION

Are you currently the subject of any investigations, reviews, disciplinary hearings or proceedings (pertaining to a dental profession) in any province, territory, state, country or elsewhere?

☐ No ☐ Yes If yes, please explain: _____

_____

Has any registration, certificate, diploma and/or license entitling you to practice a dental profession in any province, territory, state, country or elsewhere ever been denied, limited, restricted, suspended or cancelled?

☐ No ☐ Yes If yes, please explain: _____

_____

Have you been diagnosed or been treated for drug or alcohol addiction?

☐ No ☐ Yes If yes, 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?

☐ No ☐ Yes If yes, please explain: _____

_____

Have you suffered from any mental health condition that may limit your ability to practice or pose a risk of harm to patients?

☐ No ☐ Yes If yes, please explain: _____

_____

Have you suffered from any physical health condition that may limit your ability to practice or pose a risk of harm to patients?

☐ No ☐ Yes If yes, please explain: _____

_____

Have you ever had a finding in the nature of professional misconduct, unskilled practice, incompetence or incapacity, or a like finding, made against you in any province, territory, state, country or elsewhere as a dental therapist or in a profession other than dental therapy?

☐ No ☐ Yes If yes, please explain: _____

_____

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, country or elsewhere?

☐ No ☐ Yes If yes, please explain: _____

_____

I declare that the above statements made are to the best of my knowledge true and correct.

X_____ _____

Signature of Applicant Date

Mail completed form with $50.00 registration fee (cheque, money order or email transfer) to:

Saskatchewan Dental Therapists Association
P.O. Box 360 Gull Lake, SK S0N 1A0
Phone: (306)672-3699 Fax: (306)672-3619
Email: sdta@sasktel.net