



# College of Alberta Dental Assistants

166-14315 118 Ave NW  
Edmonton AB T5L 4S6

780-486-2526  
1-800-355-8940

www.abrda.ca

## Application for Advanced Practice Authorization Orthodontic Procedures – Approved Program

Use this form to apply for authorization to practice orthodontic procedures if you:

- hold a valid Practice Permit; and
- have completed formal education for orthodontic procedures through a course approved by the College

### Requirements

You must meet these requirements to qualify for authorization to practice orthodontic procedures:

1. demonstrate successful completion of an approved course
2. submit application form

### Personal Information

First Name: \_\_\_\_\_ RDA # \_\_\_\_\_

Last Name: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City/Province/Country: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Primary Phone: \_\_\_\_\_ Alternate Phone: \_\_\_\_\_

E-mail: \_\_\_\_\_

### Orthodontic Procedures Education

Include a copy of your letter or certificate of completion and/or official transcript.

Course Name \_\_\_\_\_ Completion Date (MM/DD/YYYY) \_\_\_\_\_

School Name \_\_\_\_\_

## Applicant's Statement

For each statement that you check "I Disagree" you must include a written explanation with this application.

### My Consent

The information you give us is protected. Refer to the attached Privacy and Protection of Personal Information or our website for more information about privacy and disclosure.

#### I Acknowledge and Understand that:

- By submitting this application to the College I provide my consent to the College to collect, use and disclose my personal information as required for reasonable matters including fulfillment of statutory requirements.

### True and Correct Application

#### I Agree I Disagree

- I certify that the information given and made part of this application is true and correct in every aspect.

### My Responsibilities

#### I Agree I Disagree

- I will complete all requirements for advanced-practice orthodontic procedures authorization and ensure that I have authorization from the College before I practice orthodontic procedures.
- I will practice in accordance with the *Health Professions Act, Dental Assistants Profession Regulation, Standards of Practice* and *Code of Ethics*.
- I will perform only those duties and Restricted Activities I am authorized for and I am competent in after proper education, training and experience.
- I fully understand my responsibilities and that failure to comply with any or all of the above may result in cancellation or suspension of my Practice Permit, and subsequent notification of my cancellation or suspension pursuant to statutory requirements.

## Terms and Conditions

Before submitting your application, please carefully review the following Terms and Conditions:

- Each application for advanced practice authorization will be reviewed on an individual basis.
- We will notify you by email of the result of our review.
- If you meet the eligibility requirements, we will add orthodontic procedures to your authorized practice.
- If you do not meet the eligibility requirements you must successfully complete approved orthodontic dental assistant education prior to re-applying for advanced practice authorization.
- The Registrar may request that you submit additional information in order to verify your eligibility.
- If your application is incomplete and/or if the Registrar requests additional information, we will hold your application for up to 45 days. You must complete all incomplete/missing requirements and/or submit additional information within 45 days. If you do not complete all of the requirements within that 45-day period your application will expire. If your application expires, you must begin a new application to apply for advanced practice authorization. Your expired application and verification documents will not be returned to you.
- The Registrar may refuse or defer your application for advanced practice authorization if you are the subject of investigation or discipline related to unprofessional conduct in any jurisdiction.
- Our policies are subject to change without notice. Contact us to ensure that you have the most recent information.

### General Timeline for Review of Applications

- We will notify you of the result of our assessment within 10 business days of receiving your application.
- If your application is incomplete or we require additional information, the process may take longer.

**I accept the Terms and Conditions above.**

Signed \_\_\_\_\_

Applicant's Signature

\_\_\_\_\_ Date (MM/DD/YYYY)

## Submit Your Application

Submit your application to us by mail, courier or hand delivery to:

College of Alberta Dental Assistants

166-14315 118 Ave NW

Edmonton AB T5L 4S6

We do not accept applications by fax or email.

**Do you have questions? Do you need help?** Email us at [application@abrda.ca](mailto:application@abrda.ca) or call us at 780-486-2526