



# College of Alberta Dental Assistants

166-14315 118 Ave NW  
Edmonton AB T5L 4S6

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

www.abrda.ca

## Registration Application – With NDAEB

Use this form to apply for Registration and a Practice Permit if:

- you graduated from an accredited\* dental assisting program and you passed the National Dental Assisting Examining Board (NDAEB) exam, or
- you graduated from a non-accredited dental assisting (or other dental) program, you passed the NDAEB exam, and you passed the Clinical Practice Evaluation (CPE) or completed intra-oral upgrading at an accredited\* dental assisting program.

\*Accredited by the Commission on Dental Accreditation of Canada

### Requirements

You must meet these requirements to qualify for registration:

1. demonstrate entry to practice requirements by:
  - graduate from an accredited dental assisting program and pass the NDAEB exam, or
  - graduate from a non-accredited dental assisting (or other dental) program, pass the NDAEB exam, and pass the NDAEB CPE or complete intra-oral upgrading
2. demonstrate current practice by:
  - apply within 3 years of graduating from a dental assisting/dental program, or
  - complete a Clinical Refresher Course (must be within the last three years), or
  - have at least 900 dental assistant clinical practice hours within the last three years, or
  - have other qualifications that show your practice is current (substantial equivalence), such as having completed the NDAEB CPE within the last three years
3. submit application form and applicable fees

### Identification

Include a copy of Canadian government issued identification that has your legal name and date of birth. (e.g. driver's license, passport, resident card, citizenship card)

If your legal name is different than the name on any of your verification documents you must also include a copy of legal documents that verify your name change. (e.g. marriage certificate, legal name change)

In the First, Middle and Last Name areas, provide your legal name as it appears on your identification. If you go by a different first name, provide it as your Preferred First Name. If your name has changed since birth, provide all names you have previously used as your Former Name(s).

Gender:  Female  Male      Date of Birth (MM/DD/YYYY): \_\_\_\_\_

First Name: \_\_\_\_\_ Preferred First Name: \_\_\_\_\_

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

Former Name(s): \_\_\_\_\_

## Name Tag

We will send you an RDA name tag when you are registered. We recommend that you use your first name, or preferred name, only on your name tag.

What name do you want on your name tag? \_\_\_\_\_

## Contact Information

We will send your registration documents to the address you provide below. If your address will be changing you must let us know immediately or provide a reliable "care of" address.

You must provide a personal email address. We will contact you by email to let you know the status of your application.

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

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

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

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

## Entry to Practice Requirement

You must meet at least one of the requirements in this section.

### Which of the following requirements do you meet?

- I graduated from an accredited dental assisting program and passed the NDAEB exam.**
  - include a copy of your NDAEB exam results letter
  
- I graduated from a non-accredited dental assisting (or other dental) program, passed the NDAEB exam, and passed the NDAEB CPE or completed intra-oral upgrading.**
  - include a copy of your NDAEB exam results letter, and
  - include a copy of your NDAEB CPE results letter, or
  - complete the Intra-Oral Training section below

## Current Practice Requirement

You must meet at least one of the requirements in this section. If you do not already meet any of these requirements you will need to complete a clinical refresher or the NDAEB CPE to qualify for registration.

### Which of the following requirements do you meet?

- I am applying within three years of graduating from a dental assisting (or other dental) program.**
  - complete the Dental Education section below
  
- I have at least 900 dental assistant clinical practice hours within the last three years.**
  - submit the attached Practice Hours Verification Form (see form for instructions)
  
- I have completed a clinical refresher course within the last three years.**
  - provide details below

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

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

**I have other qualifications that show my practice is current (substantial equivalence).**

For example you have completed the NDAEB CPE within the last three years.

- provide details below (if you need more space provide information on a separate sheet)
- use the attached Verification of Standing form if applicable (see form for instructions)
- include a copy of document(s) to verify the information you provide
- the Registrar will review and decide if you have substantial equivalence

**Dental Education**

Include a copy of your certificate/diploma or official transcript.

School Name: \_\_\_\_\_ Program End Date: \_\_\_\_\_  
(MM/DD/YYYY)

Location of School (City/Province/Country): \_\_\_\_\_

**Intra-Oral Training**

We will only authorize you to perform skills if you completed the intra-oral course(s) at a program that is accredited by the Commission on Dental Accreditation of Canada.

**Have you completed intra-oral course(s) since you graduated from the program you list above?**

**Yes**

- attach verification
- provide this information, if you need more space provide information on a separate sheet:

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

**No**

**Good Character and Reputation, Fitness to Practice**

**I have attached an original Criminal Record Check with Vulnerable Sector Check certificate that is no more than 90 days old.**

- You must provide the results of a Criminal Record Check that includes a Vulnerable Sector Check.
- The results certificate must be dated within 90 days.
- You must provide the original certificate or a notarized copy.

**Do you hold current or previous practice rights (registration/certification/license) in any regulated profession including dental assisting?**

**Yes**

- record details for each, if you need more space provide information on a separate sheet
- use the attached Verification of Standing form (see form for instructions)
- provide this information:

\_\_\_\_\_  
Organization From (MM/DD/YYYY) To (MM/DD/YYYY)

**No**

**Have you ever been disciplined, the subject of an alternative complaint process or are you currently being investigated by any professional regulatory body?**

**Yes**

Include written information that:

- provides the name of the professional regulating body
- describes the complaint/charges
- describes the findings/orders, if applicable

**No**

**Have you ever had conditions/restrictions or the equivalent placed on your practice by any professional regulatory body?**

**Yes**

Include written information that:

- provides the name of the professional regulating body
- describes the conditions/restrictions/equivalent on your practice

**No**

**Have you ever pleaded guilty, been found guilty or received a conditional discharge of a criminal offence in Canada or an offence of a similar nature in a jurisdiction outside Canada for which you have not been pardoned?**

**Yes**

Include written information that:

- indicates where the offence took place
- describes the offence
- describes the penalty

**No**

**Have you ever had a civil judgement against you in relation to your professional practice?**

**Yes**

Include written information that:

- indicates where the civil action took place
- describes the civil action
- describes the judgement

**No**

**Is there anything else that may have a negative impact on your fitness to practice dental assisting?**

**Yes**

Include written information that:

- describes what it is that may impact your practice

**No**

## Current Dental Employment Information

- I will be starting work or am currently employed in the dental field. (provide information below, list all employers, if you need more space provide information on a separate sheet)

Employer Name: \_\_\_\_\_ Employer City: \_\_\_\_\_

Employment Start/Return Date: \_\_\_\_\_ Average hours per week:  0-15  16-32  33+  
(MM/DD/YYYY)

Job Description: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Work E-mail: \_\_\_\_\_

- I am currently unemployed. Unemployed since (provide date): \_\_\_\_\_  
(MM/DD/YYYY)

- I am currently employed in a non-dental field. Employed non-dental since (provide date): \_\_\_\_\_  
(MM/DD/YYYY)

## 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.
- The College uses service providers to carry out its regulatory functions. By submitting this application to the College I provide my consent for the disclosure of my personal information by the College to its service providers. This includes my consent for the purposes of the *Personal Information Protection Act* and the *Personal Information Protection and Electronic Documents Act*.

### 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 registration requirements and ensure that I have a valid Practice Permit before I practice dental assisting.
- I will notify the College of name, address and employment information changes.
- 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 will meet annual renewal requirements by the renewal deadline.
- 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 and fees, please carefully review the following Terms and Conditions:

- When we receive your application we will process your Assessment Fee. The Assessment Fee is non-refundable.
- We will assess your application and notify you by email of the result of our assessment.
- If you meet the eligibility requirements, we will process your Registration Fee and issue a Practice Permit Validation Sticker to you. The Registration Fee is non-refundable.
- If your application is incomplete and/or you do not meet the eligibility requirements, we will hold your application and Registration Fee for up to 45 days. You must complete all incomplete/missing requirements and submit verification within 45 days. If you do not complete all of the requirements, including payment of the Registration Fee, within that 45 day period your application will expire and you will forfeit the \$105.00 Assessment Fee. If you begin a new application in the future you must pay the Assessment Fee again. Your Registration Fee will not be processed if your application expires (in the case of a money order it will be returned to you). Your application and verification documents will not be returned to you.
- All eligibility requirements with time restrictions (including but not limited to: verification of standing, current practice rights, graduation within 3 years of application, NDAEB CPE, refresher, practice hours and vulnerable sector check) must be current when your application is complete. If your requirements expire it may result in a change to your eligibility. In the case of an expired verification of standing or vulnerable sector check it will need to be reissued within the above noted 45 day period.
- Our registration cycle begins December 1 and ends on November 30 of the following year.
- Your Registration Fee includes malpractice liability insurance coverage.
- Fees are subject to change at any time.
- The official receipt of payment will only be issued in the name of the payer.
- Our policies are subject to change without notice. Contact us to ensure that you have the most recent information.

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

Signed \_\_\_\_\_

Applicant's Signature

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

## Before You Apply

**Have you attached a copy of:**

- identification stating your legal name and date of birth
- verification of your name change, if applicable
- verify your dental assisting/dental education
- if it has been more than 3 years since you graduated, verification of your Current Practice
- verification of your intra-oral upgrading, if applicable
- written information about your investigation/discipline proceedings, practice conditions/restrictions, criminal offences and/or civil judgements, if applicable
- information you recorded on separate sheet(s), if applicable

**If you graduated from an accredited program have you attached a copy of:**

- your NDAEB exam results

**If you graduated from a non-accredited program have you attached a copy of:**

- your NDAEB exam results
- your NDAEB CPE results

**Have you:**

- sent a Verification of Standing Form to each regulatory body you have current or previous practice rights with
- attached your original Criminal Record/Vulnerable Sector Check Certificate
- completed the Applicant's Statement
- signed and dated Terms and Conditions
- provided credit card authorization or attached money orders
- provided an official English translation for your documents that are not in English



## Fee and Payment Information

Select appropriate **Fee**.

Payment for (applicant's name): \_\_\_\_\_

**Full Fee** If your registration will take effect between December 1, 2018, and May 31, 2019, you must pay the **\$105.00 Assessment Fee** and the **\$240.00 Registration Fee**. Your Practice Permit will be in effect until November 30, 2019.

**Prorated Fee** If your registration will take effect between June 1, 2019, and November 30, 2019, you must pay the **\$105.00 Assessment Fee** and the **\$127.50 (prorated) Registration Fee**. Your Practice Permit will be in effect until November 30, 2019.

**Payment Method:**   or   We may debit your credit card account in two transactions, once for the Assessment Fee and once for the Registration Fee. We must have the *Cardholder's* signature.

**2 Money Orders** (payable to College of Alberta Dental Assistants) You must submit two separate money orders, one for the Assessment Fee and one for the Registration Fee.

*I hereby authorize College of Alberta Dental Assistants to debit my credit card account.*

\_\_\_\_\_

Card Number Expiry Date (MM/YYYY)

\_\_\_\_\_

Cardholder Name Cardholder Signature

If cardholder is other than applicant, provide cardholder mailing address and phone number:

\_\_\_\_\_  
\_\_\_\_\_

**Office Use Only**  
Registration #

Full Fee  
 Prorated Fee  
 3rd party  
Assess Pmt Date

Reg Pmt Date

## Submit Your Application

Submit your application and fees to us by mail, courier or in person to:

**College of Alberta Dental Assistants**

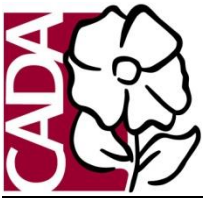
**166-14315 118 Ave NW**

**Edmonton AB T5L 4S6**

We do not accept applications by fax or email.

We will send you an email to confirm that we have received your application. We will then review your application and let you know the results within 10 business days.

**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



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## Verification of Standing

If you are or have been registered, licensed or certified anywhere (province/state/country) as a dental assistant (other than with our College) or any other regulated profession you must use this form.

1. Make enough copies of this form for each organization you are/have been a member of.
2. Use one copy for each organization.
3. You complete Part A only.
4. Leave Part B blank.
5. Send Part A and Part B to the organization you name below.
6. Verification of Standing forms are valid for 30 days after the date they are completed by the regulatory authority. Plan accordingly.

### Part A: Consent for Release

I have made application with the College of Alberta Dental Assistants for registration in order to engage in the practice of dental assisting in the province of Alberta. I, therefore, hereby irrevocably authorize and request that:

Name of organization you are/have been a member of

\_\_\_\_\_  
(hereinafter referred to as “receiving regulatory authority”)

provides to the College of Alberta Dental Assistants full disclosure of any and all information the receiving regulatory authority may have respecting my professional conduct, competence and capacity including providing a copy of any written information in my file pertaining to these matters and this shall serve as the receiving regulatory authority’s full, final and irrevocable authority for so doing.

I understand the legal implications and approve the receiving regulatory authority’s release of any information requested by the College of Alberta Dental Assistants.

I understand that I have the right to seek legal advice prior to signing this form.

**Signature of Applicant**

\_\_\_\_\_

**Print Applicant’s Name**

\_\_\_\_\_

**Applicant’s Registration, License  
or Certificate Number with  
Receiving Regulatory Authority**

\_\_\_\_\_

**Date**

\_\_\_\_\_



# Verification of Standing

## Part B: Registration/License/Certification Information

To be completed by the regulatory authority and forwarded directly to the College of Alberta Dental Assistants at:  
application@abrda.ca      780-486-2728 (fax)      166-14315 118 AVE NW  
Edmonton Alberta T5L 4S6

### Applicant's Registration/License/Certification (R/L/C) Information

Name \_\_\_\_\_ R/L/C Number \_\_\_\_\_

Profession     Dental Assistant     Other (provide professional title) \_\_\_\_\_

The applicant has held R/L/C in

\_\_\_\_\_ From \_\_\_\_\_ To \_\_\_\_\_  
Receiving regulatory authority's jurisdiction      MM/DD/YYYY      MM/DD/YYYY

#### Current Status

Practicing/active       Non-practicing/inactive       Other (specify and provide an explanation)  
 Suspended/cancelled     Provisional/temporary/conditional      \_\_\_\_\_

Has the applicant ever had terms, restrictions, conditions or limitations on her or his R/L/C?

Yes – attach a description and the dates in force       No

Has the applicant ever had her or his R/L/C suspended, cancelled, revoked or struck from a Register of your organization?

Yes – attach a description and the dates in force       No

Has the applicant ever been the subject of a formal complaint, investigation or disciplinary proceeding in the nature of professional misconduct, incompetency or incapacity, or a like finding made against her or him?

Yes – attach a description and the dates in force       No

Has the applicant always been in compliance with your competence/professional development/quality assurance program requirements?

Yes       No – attach a description and the dates in force

### Regulatory Authority's Information

Organization Name and Address

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Telephone \_\_\_\_\_

Email \_\_\_\_\_

Corporate Seal

I certify that the information provided on and attached to this form are true statements of the R/L/C record for the applicant.

Signature \_\_\_\_\_

Print Signatory's Name \_\_\_\_\_

Date \_\_\_\_\_

Signatory's Title \_\_\_\_\_



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## Practice Hours Verification Form

- Use this form to report your practice hours.
- Practice hours may include employment and volunteer hours.
- Complete one form for each employer or volunteer role.

Name \_\_\_\_\_ RDA# \_\_\_\_\_

### Practice Hours for CCP

Plan Year \_\_\_\_\_ Number of Hours Completed \_\_\_\_\_

- complete Verification below
- upload this completed form to your Practice Hours record at *My Practice Hours*

### Practice Hours for Registration or Reinstatement Application

Number of Hours Completed Within Last 3 Years \_\_\_\_\_

Type of Services Provided \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Hours Completed Between \_\_\_\_\_ and \_\_\_\_\_  
Start Date End Date

- complete Verification below or attach documents that verify your practice hours
- attach this form to your registration or reinstatement application

### Verification

Your employer or volunteer organization representative may verify your practice hours.

Employer or Volunteer Organization \_\_\_\_\_

Verified By (print name) \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

Job Title/Position \_\_\_\_\_

Contact Information \_\_\_\_\_  
(Phone or Address or Email)



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## Privacy and Protection of Personal Information

The College of Alberta Dental Assistants collects, uses and discloses personal information for the purpose of regulating dental assisting, as described in the *Health Professions Act* (HPA) and *Dental Assistants Profession Regulation*.

As a regulatory body, we comply with the *Personal Information Protection Act* (PIPA) and the *Personal Information Protection and Electronic Documents Act* (PIPEDA).

The information we collect, use and disclose may not apply to all membership categories.

## Collection, Use and Disclosure

*Identification Data is used to identify members, and for workplace demographics*

- full name, maiden or other names, date of birth and gender (Government-issued identification is used to verify identity)

*Regulatory Data is used to determine status, restrictions, credentials, and conditions*

- date of initial registration
- the member's unique registration number (RDA#)
- whether the member's registration is restricted to a period of time (usually Dec 1 to Nov 30)
- any conditions imposed on the member's practice permit (e.g. provisional)
- the status of the practice permit (e.g. registered, suspended or cancelled)
- membership status (e.g. leave of absence, student or courtesy)
- school of training, graduation date, supporting documentation (education credentials)
- practice specializations (e.g. ortho, scaling)
- restricted activity authorizations (skills)
- qualifications documentation (NDAEB certification, education, etc.)
- relevant information from a disciplinary order or criminal record
- whether the member is registered as a dental assistant, or another profession, in another jurisdiction (e.g. verification of standing)
- competence documentation (learning plans, verification of learning, practice hours – collected for a specific purpose)
- professional conduct information (investigation/disciplinary)
- verification of malpractice insurance coverage

*Contact Data is used to contact members*

- home address, home phone, mobile phone and email

*Employer Data is used to inform employers of cancelled/suspended status, competence program verification, and to contact members*

- employment status, job description, employer name, start and end dates, hours per week, work telephone, and email

*Awards Data is used for historical information for award purposes*

- positions held within the organization
- professional awards or honours

### *Other data collected through communications with members*

- correspondence, consent forms, user IDs/passwords and payment information

### *Information disclosed upon general enquiry (required by HPA)*

- a regulated member's full name and registration number
- Practice Permit status (registered, provisional, cancelled or suspended)
- registration period and any conditions /restrictions on the practice permit
- authorized practice, authorization to provide restricted activities/specializations (skills)
- disciplinary action (information released according to and within legislative limitations)

### *Information disclosed to legislative and regulatory organizations*

#### **Alberta Provider Directory, provided for workplace demographics, initiatives and planning, for anyone who is or was a regulated member**

- RDA#, status (reason for changing to non-regulated status), name, gender, date of birth, registration credentials, personal contact information, school of training and graduation date, dates of registration

#### **Regulatory - Verification of Standing/Letters of Standing/Certificate of Professional Conduct**

- RDA#, name, registration status history, authorized practice (skills), disciplinary proceedings (if applicable), continuing competence audit status, reason for cancellation/suspension

#### **Malpractice Insurance Company**

- Regulated members' name, RDA number, start date of current status and mailing address will be provided to the insurance company, for the purposes of the provision of malpractice insurance coverage

#### **Service Providers**

In performing our regulatory responsibilities we engage service providers both inside Alberta and outside of Alberta. This includes, but is not limited to: printing and mailing services, electronic communication and data storage, database management, information technology support, document shredding and insurance. We disclose information to our service providers that is necessary to carry out our business and only for the purpose of carrying out our business.

## **Protection**

We protect personal information by securely storing paper files, using authentication processes to protect electronic data, and requiring employees and volunteers to follow confidentiality policies.

## **Access**

We provide individuals with access to their own personal information as set out in PIPA and/or PIPEDA.

More details on our compliance with PIPA are available on our website at [www.abrda.ca](http://www.abrda.ca) > **About CADA > Legislation and Regulatory Information > Privacy**. If you have any questions or concerns contact the College Privacy Officer at the College office.