



Application for Registration

26-2625 Joseph Howe Drive, Halifax NS B3L 4G4
 Phone:(902) 444-7241, Fax: (902) 444-7242, Email: info@cdhns.ca

You must be registered and licensed with the CDHNS in order to practice dental hygiene in Nova Scotia.
 The College will confirm when your application has been processed and registration granted.
 Allow a minimum 4-6 weeks prior to your employment start date for processing of your application.

Please use ink and print clearly in block letters and check the appropriate boxes. Should the space provided prove inadequate, please append additional information.			
Personal Information			
Surname:	First:	Middle:	Place a passport size photo taken not more than 6 months prior to application date here
Is this your legal name: <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name:	Former name(s):	
Name to appear on Register: (Your name, as it appears on the register, must be the name you use while practicing dental hygiene and in all correspondence with the CDHNS. Your name will appear on the Public Register)			
Place of birth Country:	Province/State:	City:	Birthday (dd/mm/yy): Gender: <input type="checkbox"/> M <input type="checkbox"/> F
<small>Non Canadian citizens must enclose a copy of your Employment Visa under the Canadian Immigration Act.</small>			
Eye Colour:	Height:	Identifying marks:	
Home Address Street:		PO Box:	City:
Province:	Postal Code:	Home Phone:	Cell:
Email (Must be provided: used for announcements, newsletters, etc)			
Future Employment Information			
Employer:			
Address Street:			PO Box:
City:	Province:	Phone:	Fax:

Post Secondary Education (List all degrees/diplomas obtained)				
Program	University/College	City/Province/Country	Grad Year	Surname on Credential

An **official transcript** of your dental hygiene education which indicates proof of graduation must be sent **directly** to the CDHNS by the institute. If you graduated from a non-accredited program, you should also submit evidence you have completed a Clinical Competency Assessment.

Are you licensing for the purpose of entering the Bachelor of Dental Hygiene Program? No Yes

Specific Dental Hygiene Practice Skill						
Practice Area	Part of Dental Hygiene Program	Separate Module	University/College/Institute	City/Province/Country	Year	Practicing Now
Local Anaesthetic	<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/> Yes <input type="checkbox"/> No
Restorative	<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/> Yes <input type="checkbox"/> No
Orthodontics	<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/> Yes <input type="checkbox"/> No

A **certified copy** of the Certificate of Completion for any specific practice skill completed as a separate module must be provided

National Dental Hygiene Certification Examination (NDHCE)		
<input type="checkbox"/> I have successfully completed the NDHCE	Date of Issue:	Certificate Number:
<input type="checkbox"/> I was previously grand parented a NDHCB certification	Date of Issue:	Certificate Number:
<input type="checkbox"/> I wrote the NDHCE on _____ and examination results are not yet available		
<input type="checkbox"/> I have written the NDHCE but have not successfully completed it		
<input type="checkbox"/> I have never written the NDHCE and have not been grand parented		

A **certified copy** of the NDHCB certificate issued must be provided

Language Proficiency (Provide a copy of English proficiency tests completed)	
First Language:	
Language of dental hygiene education:	
English language proficiency test completed: <input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, date:
Other languages I can practice dental hygiene:	

Cardio Pulmonary Resuscitation (Copy of CPR certificate must be submitted)	
<input type="checkbox"/> I have completed a CPR course Level C or Level HCP within the last 12 months	Date Completed:

Jurisprudence NS or Self Initiation Course NS	
<input type="checkbox"/> I have completed the Jurisprudence for NS course	Date Completed:
or	
<input type="checkbox"/> I have completed the Self Initiation Course for NS	Date Completed:
or	
<input type="checkbox"/> I am applying for the equivalent under Regulation 8(1)(h) and am providing a written letter of application	

Either the Jurisprudence NS course or the Self Initiation Course must be completed before applying to the CDHNS. If the Jurisprudence course is completed, the Self Initiation Course must be completed within two years of registration.

Previous Dental Hygiene Practice			
Are you currently or have you ever been registered, licensed and/or certified to practice dental hygiene in any other province, state, or country in the last five (5) years? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Jurisdiction	Province/State/Country	Certificate/Registration/Licence Number	Dates Registered From To
A letter of good standing sent directly to the CDHNS by the jurisdiction(s) in which you were or are registered or licensed is required			

Employment History & Practice Hours			
Please list your dental hygiene employment in the past five (5) years. List the most recent employer first. If more space is needed, please append additional information.			
1. Employed From To	Employer		
Address Street:	City:	Province:	Postal Code:
Business Phone:	Business Fax:	Total number of hours worked:	
Position: <input type="checkbox"/> Full-time permanent (30+ hours) <input type="checkbox"/> Part-time permanent <input type="checkbox"/> Full-time temp/contract <input type="checkbox"/> Part-time temp/contract	Practice Setting: <input type="checkbox"/> General Dentistry <input type="checkbox"/> Specialty Dentistry, specify: <input type="checkbox"/> Community/Public Health <input type="checkbox"/> University/College/Institution <input type="checkbox"/> Hospital <input type="checkbox"/> Other		Primary Area(s) of Responsibility: <input type="checkbox"/> Direct client care <input type="checkbox"/> Administration <input type="checkbox"/> Teaching <input type="checkbox"/> Research <input type="checkbox"/> Consulting <input type="checkbox"/> Other
2. Employed From To	Employer		
Address Street:	City:	Province:	Postal Code:
Business Phone:	Business Fax:	Total number of hours worked:	
Position: <input type="checkbox"/> Full-time permanent (30+ hours) <input type="checkbox"/> Part-time permanent <input type="checkbox"/> Full-time temp/contract <input type="checkbox"/> Part-time temp/contract	Practice Setting: <input type="checkbox"/> General Dentistry <input type="checkbox"/> Specialty Dentistry, specify: <input type="checkbox"/> Community/Public Health <input type="checkbox"/> University/College/Institution <input type="checkbox"/> Hospital <input type="checkbox"/> Other		Primary Area(s) of Responsibility: <input type="checkbox"/> Direct client care <input type="checkbox"/> Administration <input type="checkbox"/> Teaching <input type="checkbox"/> Research <input type="checkbox"/> Consulting <input type="checkbox"/> Other

3. Employed From To	Employer		
Address Street:	City:	Province:	Postal Code:
Business Phone:	Business Fax:	Total number of hours worked:	
Position: <input type="checkbox"/> Full-time permanent (30+ hours) <input type="checkbox"/> Part-time permanent <input type="checkbox"/> Full-time temp/contract <input type="checkbox"/> Part-time temp/contract	Practice Setting: <input type="checkbox"/> General Dentistry <input type="checkbox"/> Specialty Dentistry, specify: <input type="checkbox"/> Community/Public Health <input type="checkbox"/> University/College/Institution <input type="checkbox"/> Hospital <input type="checkbox"/> Other	Primary Area(s) of Responsibility: <input type="checkbox"/> Direct client care <input type="checkbox"/> Administration <input type="checkbox"/> Teaching <input type="checkbox"/> Research <input type="checkbox"/> Consulting <input type="checkbox"/> Other	
Please total your practice hours for the preceding three years in the space provided.			
Year	Year	Year	Total
Hours	Hours	Hours	

Continuing Education
Complete Attachment A and submit with application. Does not apply if you have graduated within the past three years.

Payment of Fees		
<input type="checkbox"/>	Application fee. This is a non-refundable fee and must be sent in separate payment	\$ 75.00
<input type="checkbox"/>	Registration fee	\$ 125.00
<input type="checkbox"/>	Practicing Licence (includes CDHA membership and liability insurance)	\$ 600.00
<input type="checkbox"/>	Practicing Licence Only (must provide proof of CDHA membership and liability insurance)	\$ 438.00
	Total Enclosed:	
All payments must be either certified cheques or money orders. We cannot accept personal cheques for registration.		

For office use			
Application Received: _____	Registration Granted: _____	Registration Number: _____	
Dal: _____	Other: _____	Accred.: _____	Non Accredited: _____
Self Initiation Yes: _____	No: _____	Local Anaesthetic: _____	Restorative: _____ Ortho: _____
Fees: Application _____	Registration _____	Licence _____	
Registrar's Signature: _____	Date: _____		

Good Character and Fitness to Practice: Applicant's Declaration

- 1. Have you ever applied for registration in Nova Scotia before? Yes No
 - 2. Are you currently or have you ever been under investigation for any complaints, or the subject of any discipline proceedings which would prohibit or restrict your ability to engage in the practice of dental hygiene? Yes No
 - 3. Have you ever pleaded guilty to or been convicted of a criminal offence for which a pardon has not been issued? Yes No
 - 4. Have you ever had a finding of professional misconduct, incompetency, incapacity, or any like finding, either inside or outside Nova Scotia as a dental hygienist or in a health professions other than dental hygiene? Yes No
 - 5. Do you have a physical or mental condition, disorder, or addiction to alcohol or drugs that interferes with your ability to practice dental hygiene? Yes No
- If you answered yes to any of the above, please provide a written explanation*
- 6. Have you been advised to read and be familiar with the Dental Hygienists Act of NS, Regulations? Yes No
 - 7. Do you intend to practice dental hygiene in the province of Nova Scotia? Yes No

I, _____, certify that the information provided on this form and in its attachments is correct, complete, and true in every respect. I understand that this declaration has the same significance as giving one under oath.

The Dental Hygienists Act of Nova Scotia Section 27 states that: A person who knowingly furnishes false information in an application pursuant to this Act, or in any statement or return required to be furnished pursuant to this Act or the regulations, is guilty of an offence.

I understand that making a false or misleading statement on this application could result in rejection of the application, or discipline matters up to and including revocation.

If granted registration, I agree to practice ethically, abide by The Dental Hygienist Act, Regulations, and By-Laws of the College of Dental Hygienists of Nova Scotia.

I agree should any charges be brought against me by the Registrar of the College of Dental Hygienists in regard to my conduct in carrying on my profession, all hearings will be held in the Province of Nova Scotia.

I authorize the CDHNS to seek additional information from education institutions, regulatory agencies, or other sources as necessary in order to process my application for registration and, I also authorize all such institutions, agencies, or other sources to release such information to the CDHNS and for so doing let this be good and sufficient authority.

Signature

Date

Declaration and statements taken and signed before me, and certified that the photograph attached to this application is the likeness of the applicant, in the county of _____, in the province of _____, this _____ day of _____, 20_____.

Commissioner of Oaths

Printed Name:

Phone Number:

Stamp/Seal