Registrar, Professional Licensing
Government of the Northwest Territories
Department of Health and Social Services
7th Floor, 5015 – 49 ST
Box 1320 Yellowknife, NT X1A 2L9
Phone: (867) 767-9067 Fax: (867) 873-0484
Professional_Licensing@gov.nt.ca

REQUIREMENTS FOR DENTAL REGISTRATION/LICENCE

1. Complete **application** form, photograph attached.

2. **Certified true copy** of dental degree (certified by Notary Public or Commissioner for Oaths); **OR** a transcript of records, mailed directly to the Registrar from the Dental School. Translated if not in English.

3. Photocopy of **National Dental Examining Board of Canada Certificate** (NDEB).

Note: Applicants who do not have NDEB are eligible for licensing in the NWT providing they hold full, unrestricted licence in a province or Territory; or provide evidence they are eligible to hold full, unrestricted licence in a province or Territory.

4. If applying as a specialist, provide evidence of having successfully completed a specialty training program accredited by the Commission on Dental Accreditation of Canada in that specialty. If applicable, enclose copy of certification by Royal College of Dentists of Canada.

5. **Certificate of standing** from any jurisdiction applicant is/was licenced. Must be sent directly to the Registrar in the NWT from the licensing authority.

6. Current and detailed **curriculum vitae/resume**.

7. **Three current letters of professional reference** from individuals who have knowledge of applicant's work. At least two must be dentists. These references must be sent directly to the Registrar from the referee.

8. Photocopy of birth certificate or citizenship documentation (if Canadian citizen), or valid immigration or work permit (if not a Canadian citizen).

9. Cheque, money order or credit card authorization payable to Government of the N.W.T., for:

- **registration & annual Licence** - $323.00 ($108 registration plus $215 due annually) - licence expires March 31st following date of issue, renewable upon payment of fee;

OR

- temporary permit - $108.00, valid for 3 months from date of issue (may be extended for one further three-month period upon application and $108)

**** Failure to ensure all documents are forwarded to the Registrar's Office as stipulated above will delay and possibly prevent licensing**

Allow two weeks from when Registrar receives required documentation to when licensure can be expected.

Applicants must be licenced BEFORE working in the N.W.T.

APPLICATION TO PRACTICE DENTISTRY

Provide a recent passport-type photograph of yourself (taken within the last six months) Application considered incomplete without photograph.	_____ Last Name First Name Middle Name _____ (Apt #) (Street or postal box number) _____ (City, Town, Village) (Province/State) (Postal/Zip Code) Telephone: _____ Fax: _____ E-Mail: _____ Note: If not advised differently, iicence and renewal notices sent to this address.

Date of Birth: (dd/mm/yy) _____ **Canadian Citizen:** __ Yes (attach copy of birth certificate or proof of citizenship) __ No (attach copy of work auth. or immigration document	**Language Fluency:** __ English __ French Other, specify:_____

Location and Dates of Planned Practice in N.W.T.:
Location/Clinic(s) _____
Anticipated Start Date: _____ Note: Applicant must be fully licensed before beginning work.
Type of Licence Requested: _____

Dental Degree (attach certified copy of degree, translated if not in English)
____/____/____ _____
(Date of Graduation) Name of School - Province/State/Country

Qualifying Program (if applicable)
____/____/____ _____
(Date of Graduation) Name of School - Province/State/Country

National Dental Examining Board Certification (NDEB) - attach photocopy
Date received: ___ / ___ / ___
dd mm yy

REGISTRATION IN OTHER JURISDICTIONS: (include previous and current):

Province/Territory/Country	**Licence Dates**	**Licence Number**

References: (Provide the names, address and phone number of 3 professionals with whom you have been associated in the last three years. At least two must be dentists.
1) _____ 2) _____ 3) _____
_____ _____ _____
_____ _____ _____

Personal Information (Check the appropriate box. **If answer is yes to any of the following questions, provide full explanation/details on a separate sheet of paper.**)	Yes	No
1. Have you ever been refused a licence, permit or registration to practice dentistry in any jurisdiction?		
2. Have you ever had a licence, registration or right to practice in any jurisdiction revoked, suspended or restricted in any way?		
3. Are you presently the subject to an allegation, complaint or investigation for any reason whatsoever by any licensing authority?		
4. Are you aware of any inquiry likely to be made by any authority, licensing or otherwise, with respect to your conduct, personal behavior or competence?		
5. Have you ever been convicted of an indictable offence for which you have not been pardoned? If yes, specify, when, where and what charge. Attach particulars.		
6. To your knowledge, do you currently have any contagious or infectious disease?		
7. Have you previously applied for, or have been issued, a licence or certificate of registration in the Northwest Territories. If yes, indicate year, if known? Licence # (if known)		

Declaration

I authorize the Dental Registration Committee to investigate and obtain from any person or persons, such information as may be required in relation to this application. **I certify** that the statements made by me in this application are true and complete. **I am aware** that misrepresentation or falsification may result in rejection of my application or withdrawal of registration.

Signature: _____ Date:_____

When complete, forward with required attachments, to:

Registrar, Professional Licensing
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Department of Health and Social Services
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If paying your fees by credit card, complete the following: **(See list of requirements for fees.)**

Name on Card: _____
Card Number: _____
Card Expiry Date: _____
Amount: _____$323.00_____

Authorized Signature: _____

This personal information is being collected under the authority of the *Dental Profession Act* of the NWT and will be used to process Application for Registration. The information is protected by the privacy provisions of the *Access to Information and Protection of Privacy Act* of the NWT. If you have any questions about the collection, contact the Registrar=s Office at the above address.

REFERENCE FORM FOR DENTAL THERAPISTS FOR DENTAL THERAPY LICENCE IN THE NORTHWEST TERRITORIES

PLEASE RETURN COMPLETED FORM TO:

Registrar, Professional Licensing
Government of the Northwest Territories
Department of Health and Social Services
7th Floor, 5015 – 49 ST
Box 1320 Yellowknife, NT X1A 2L9
Phone: (867) 767-9067 Fax: (867) 873-0484
Professional_Licensing@gov.nt.ca

NAME OF APPLICANT ***(PLEASE PRINT):***	
I authorize the referee to disclose to the Registrar, Professional Licensing of the Northwest Territories, information relevant to licensure that would otherwise be confidential and I waive any right of disclosure of the same and agree that communication between the Registrar and the referee shall be privileged. This personal information is being collected under authority of the Dental Auxiliaries Act. It is protected by the privacy provisions of the *Access to Information and Protection of Privacy Act.*	
SIGNATURE OF APPLICANT:	DATE:
NAME OF REFEREE (PLEASE PRINT):	APPLICANT TELEPHONE/FACSIMILE #:

INSTRUCTIONS FOR REFEREE: Your personal knowledge of this applicant is important in judging suitability for licensure. Any problems or concerns that you identify below should be explained. Please use the back of this form if required.

1. Indicate dates where, and in what capacity, you worked with the applicant. Must be within the last three years.

_____

_____

	YES	NO
2. Are you aware of any problems regarding the applicant's physical or mental health or of any alcohol or drug problems?	☐	☐
3. Are you aware of any complaints regarding the applicant from patients, dentists, or other dental therapists?	☐	☐
4. Do you know of any ethical problems the applicant has which relate to dental therapy practice?	☐	☐
5. Are you aware of any aspects of the applicant's personality that may cause difficulties in professional interpersonal relationships?	☐	☐
6. Is there any reason why you would not consider the applicant to have adequate knowledge, skills, and judgement required to provide dental therapy services.	☐	☐

7. Have you any additional information with respect to the applicant's professional or ethical conduct that may affect their application for registration?

_____

_____

_____

SIGNATURE OF REFEREE:	**DATE:**
ADDRESS:	
TELEPHONE #:	**FACSIMILE #:**

The Reference may fax this to the above number but ensure original is mailed promptly.