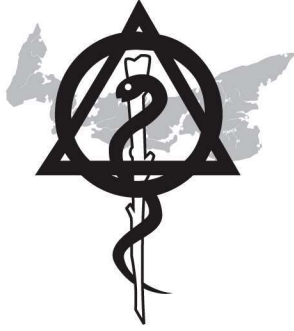


**DENTAL COUNCIL  
PRINCE EDWARD ISLAND**



184 Belvedere Ave  
Charlottetown, PEI C1A 2Z1

Tel: (902) 628-8156  
Fax: (902) 892-0234  
info@dcpei.ca

FOR OFFICE USE
Date application received: _____
Approved by: _____
Date license granted: _____
Registration No. _____

*Every false statement knowingly made by the applicant in this paper, or connived at by him/her in any clause in this application, is good cause for rejection of application or for revocation of license after license has been granted.*

**APPLICATION FOR REGISTRATION  
(Please Print)**

**PERSONAL DATA**

- NAME \_\_\_\_\_  

(First)
(Middle)
(Surname)
- BUSINESS ADDRESS \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_ POSTAL CODE \_\_\_\_\_  
 TEL: \_\_\_\_\_ FAX: \_\_\_\_\_  
 EMAIL ADDRESS: \_\_\_\_\_
- PLACE OF BIRTH: \_\_\_\_\_ DATE OF BIRTH: *(M/D/Y)* \_\_\_\_\_

**PRE-DENTAL EDUCATION**

- SECONDARY SCHOOL (Last one attended):  
 NAME \_\_\_\_\_ LOCATION \_\_\_\_\_
- COLLEGES OR UNIVERSITIES ATTENDED:  

Name of Institution	Location	Diploma or Degree	Dates	
			From	To
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

**DENTAL EDUCATION**

- DENTAL SCHOOL ATTENDED:  

Name of Institution	Location	Diploma or Degree	Dates	
			From	To
_____	_____	_____	_____	_____

7. GRADUATE DENTAL SCHOOLS ATTENDED:

Name of Institution	Location	Diploma or Degree	From	Dates	To
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

ARE YOU A MEMBER/FELLOW (i.e. Part I/Part II) of the RCDC? IF YES, WHAT CATEGORY?

\_\_\_\_\_

8. NDEB CERTIFICATE NO. \_\_\_\_\_ DATE ISSUED \_\_\_\_\_

(Attach copy)

**NAME**

9. HAS YOUR SURNAME EVER BEEN CHANGED?  
IF YES, DATE AND PLACE OF SUCH CHANGE \_\_\_\_\_

ORIGINAL SURNAME \_\_\_\_\_

**LICENSE**

10. LIST OTHER JURISDICTIONS WHERE YOU ARE OR WERE LICENSED TO PRACTISE.

\_\_\_\_\_

**PRACTICE LOCATIONS/INFORMATION**

11 LIST ALL LOCATIONS IN WHICH YOU HAVE PRACTISED DENTISTRY SINCE GRADUATION.

Address	From	Dates	To
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

12 LIST NAMES AND ADDRESSES OF DENTISTS BY WHOM YOU WERE EMPLOYED SINCE GRADUATION.

Name	Address	From	Dates	To
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

IT IS UNDERSTOOD AND I HEREBY AUTHORIZE AND GIVE CONSENT TO THE DENTAL ASSOCIATION OF PRINCE EDWARD ISLAND TO CONTACT ANY OF THE ABOVE PRACTICE LOCATIONS.

**PROFESSIONAL LIABILITY INSURANCE**

13. STATE PROFESSIONAL LIABILITY (MALPRACTICE) INSURANCE CARRIER \_\_\_\_\_  
\_\_\_\_\_  
EFFECTIVE DATE: \_\_\_\_\_  
AMOUNT: \_\_\_\_\_ (*Attach proof of malpractice insurance coverage*)

**LICENSE STATUS**

14. HAS ANY LICENSE ENTITLING YOU TO PRACTICE DENTISTRY EVER BEEN REVOKED OR SUSPENDED?  
YES \_\_\_\_\_ NO \_\_\_\_\_

IF YES, GIVE FULL DETAILS: \_\_\_\_\_  
\_\_\_\_\_

15. HAVE YOU EVER BEEN REFUSED A LICENSE BY ANY JURISDICTION (IN ANY HEALTH CARE FIELD) TO WHICH YOU HAVE APPLIED TO PRACTICE?  
YES \_\_\_\_\_ NO \_\_\_\_\_

IF YES, GIVE FULL DETAILS: \_\_\_\_\_  
\_\_\_\_\_

16. WHILE ATTENDING AT A POST-SECONDARY INSTITUTION, HAVE ALLEGATIONS OF MISCONDUCT, INCLUDING ACADEMIC MISCONDUCT, EVER BEEN MADE AGAINST YOU OR HAVE YOU EVER BEEN SUSPENDED, REQUIRED TO WITHDRAW, EXPELLED OR PENALIZED BY A POST SECONDARY INSTITUTION FOR MISCONDUCT?  
YES \_\_\_\_\_ NO \_\_\_\_\_

IF YES, GIVE FULL DETAILS: \_\_\_\_\_  
\_\_\_\_\_

**CRIMINAL OFFENCE**

17. HAVE YOU EVER BEEN CONVICTED OF, OR INDICTED FOR ANY CRIME? YES \_\_\_\_\_ NO \_\_\_\_\_

IF YES, STATE THE FACTS IN THIS CASE: \_\_\_\_\_

**ILLNESS**

18. HAVE YOU EVER BEEN TREATED FOR MENTAL ILLNESS, DRUG ADDICTION OR ALCOHOLISM?  
YES \_\_\_\_\_ NO \_\_\_\_\_

ARE YOU FREE FROM CONTAGIOUS OR INFECTIOUS DISEASE? YES \_\_\_\_\_ NO \_\_\_\_\_

GIVE FULL DETAILS: \_\_\_\_\_  
\_\_\_\_\_

**DECLARATION**

I HEREBY SOLEMNLY SWEAR:

1. That I am willing to uphold the honor and dignity of the Profession of Dentistry, and if registered as a member of The Dental Association of Prince Edward Island, will do so, and
2. That I undertake upon such Registration that in the course of the practice of the Profession of Dentistry I will practise the Profession in a professional and becoming manner and in accordance with the Act and the By-Laws of the Association; and
3. That the statements made in the items number 1 to 18 inclusive above are true.

I make this solemn declaration, conscientiously believing all the above statements to be true and knowing that it is of the same force and effect as if made under oath.

Country of \_\_\_\_\_

City of \_\_\_\_\_

Province of \_\_\_\_\_

This \_\_\_\_\_ day of \_\_\_\_\_ 20\_\_\_\_



\_\_\_\_\_  
Signature of applicant

\_\_\_\_\_  
*A commissioner for Oaths, Notary Public, etc.*