The College of Dental Surgeons of Saskatchewan

Application for Registration and Licensure

General Practitioner

Return application with supporting documents and registration fee to:
201 1st Ave S
1202 The Tower at Midtown
Saskatoon, SK S7K 1J5

Attach Recent Head & Shoulders Photograph Here (Passport-Style) Or Email Photo to: cdss@saskdentists.com

All information requested in this application must be provided; if application is not complete, it may be returned or rejected.

A $500 non-refundable application fee must accompany this form. *(Cheque, Visa or MC.)*

Card #: ☐☐☐☐ Expiry: ☐☐ CVD: ☐

Name on credit card: _____

Every false statement knowingly made, or connived, by the applicant in any clause in this application is good cause for the rejection of the application or for revocation of license.

1. Name: _____
(First Name) (Last Name) (Middle Initial)

2. Mailing Address: _____
(Unit #, Street / Box #) (City, Province/State) (Postal/Zip Code)

3. Email Address: _____ 4. Phone #: _____

5. Birth Date: _____ 6. Place of Birth: _____
(Day/Month/Year) (City/Province/Country)

7. Present Status: ☐ New Graduate ☐ Previously Licensed Dentist ☐ Student

8. Colleges/Universities Attended: Dates: **(Include a certified copy of any dental diplomas)**

_____ _____ _____

_____ _____ _____

_____ _____ _____

9. National Dental Examining Board certification #: _____ **(Include a copy of your NDEB certificate)**

10. Licensing History:
Province / State / Country: Dates: Specialty:

_____ _____ _____

_____ _____ _____

_____ _____ _____

You must request a Certificate of Standing be sent directly to the CDSS from all jurisdictions where you have been registered/licensed.
-------CERTIFICATES SUBMITTED BY AN APPLICANT WILL NOT BE ACCEPTED-------

11. Expected start date in Saskatchewan: _____

12. Are you currently licensed to practice in any other jurisdictions? (Name each: _____) YES ☐ NO ☐

13. Have you been actively practicing dentistry / treating patients in the last 2 years? YES ☐ NO ☐

14. Do you plan to be a faculty member at the U of S, Sask Polytechnique or _____? YES ☐ NO ☐

If yes: Full-time? ☐ Part-time? ☐ Will you also practice? YES ☐ NO ☐

15. In the past 12 months, have any complaints, investigations and/or discipline cases been made against you alleging Professional or Academic Misconduct / Incompetence in any jurisdiction YES ☐ NO ☐

16. Has any license entitling you to practice dentistry ever been suspended or revoked? YES ☐ NO ☐

17. Have you ever been convicted of a criminal offence? YES ☐ NO ☐

18. Will your professional liability insurance be provided by CDSPI? If other provider please list _____ YES ☐ NO ☐

19. Have you had any Professional Liability Insurance Settlements in any jurisdiction including Saskatchewan? YES ☐ NO ☐

20. Have you ever been found guilty of negligence, malpractice or incompetence in a Superior Court? YES ☐ NO ☐

21. Are you aware of any injury, dependency, infection, disorder or other condition that would impair your ability to practice safely and competently? YES ☐ NO ☐

22. Is your basic life support training current? YES ☐ NO ☐

23. Please indicate the level of sedation that you practice: None ☐ Mild ☐ Moderate ☐ Deep ☐

(If you practice sedation please read and understand the CDSS Sedation Standard/Guidelines)

24. If you plan to administer Nitrous Oxide in SK will you have a scavenger system? YES ☐ NO ☐

25. Have you read and understood the CDSS Infection Prevention and Control Standard? YES ☐ NO ☐

26. Have you read and understood the CDSS Advertising Guidelines? YES ☐ NO ☐

27. Indicate languages other than English in which you can provide services: _____

28. Will you be affiliated with more than one dental facility in Saskatchewan? YES ☐ NO ☐

If you answered 'yes' to questions #16-18 or #20-22, please include a brief written summary (on a separate page) elaborating on the circumstances relating to your response.

29. Please fill-in the following information for **ALL** SK facilities in which you plan to practice at.

Name of Facility: _____
(As it appears publicly in external advertising.)

Address of Facility: _____
(Include complete mailing address and if different, include street address as well.)

Facility Ph #: _____ **Facility Fax #:** _____ **Afterhours Ph #:** _____

Website: _____ ****Is this facility owned by a non-CDSS member?** ☐ Yes ☐ No

Indicate your relationship to this facility *(Choose one only)*: ☐ owner ☐ associate ☐ supervisor at a U of S dental facility ☐ operate in a health region O.R. ☐ surgicentre contract ☐ long-term care facility contract

Will you practice at this location? ☐ Yes ☐ No (*If this is a proposed mobile facility, additional approval by Council is required.)*

External Sterilizer Monitoring Service Used at Facility *(eg: U of S)*: _____

***Preferred Email Address:** _____
(Using the same email address as another CDSS member will result in not having access to the member-side of the CDSS website)

Name Printed: _____ **Signature:** _____ **Date:** _____

**Please be aware that the preferred email address you provide will be used to distribute: CDSS Alerts, e-Newsletters, Continuing Education*

I HEREBY MAKE APPLICATION to become registered as a member of the College of Dental Surgeons of Saskatchewan as provided under the Dental Disciplines Act of Saskatchewan.

If granted a license to practice dentistry in Saskatchewan, I solemnly promise and undertake to faithfully and truly submit and conform to and obey, all bylaws, standards and orders of the College of Dental Surgeons of Saskatchewan and that I will practice the profession in accordance with the Dental Disciplines Act.

AFFIDAVIT: I make this solemn declaration believing all the above statements to be true and knowing that it is of the same force and effect if made under oath and by virtue of the Canada Evidence Act, 1893

Taken and declared before me in the City of _____ , Province of _____ , this _____ day of _____ , 20_____.

_____

****A Commissioner of Oaths or Notary Public**
(must be signed & stamped/embossed with seal)**

_____

(SIGNATURE OF APPLICANT)

(To be signed in front of a Notary Public or Commissioner of Oaths)

(office use only)

CDSPI confirmation of insurance letter	YES___ NO___
Photo	YES___ NO___
Certified/Notarized copy of Diploma(s)	YES___ NO___
Certificate(s) of Standing	YES___ NO___
Consent to Release Information	YES___ NO___
Fee Paid	YES___ NO___
Good Character Declaration	YES___ NO___

This is to certify that _____was granted **registration** number _____on the _____ day of _____ 20_____.

_____

(Registrar)
COLLEGE OF DENTAL SURGEONS OF SASKATCHEWAN

This is to certify that _____was granted a _____ **license** with number _____on the _____day of _____ 20_____.

SEAL

_____

(Registrar)
COLLEGE OF DENTAL SURGEONS OF SASKATCHEWAN

FACILITY / CLINIC REGISTRATION

**** One registration <u>for each facility / clinic</u> to be completed by the Comprehensive Authorized Practice Director****

Each question on this page must be initialed by the Comprehensive Authorized Practice Director signing below.

Please refer to the CDSS Practice of Dentistry, Clinic Facilities Standard for more information. (www.saskdentists.com / member-site / Professional Resources / Professional Practice Standards / Section I. (i).

1. Facility / Clinic Name: *(As it appears in external advertising)* _____
2. Address of Facility / Clinic: (*Include mailing address if different)* _____
3. Facility / Clinic Website: _____
4. Facility / Clinic Phone #: _____
5. Facility / Clinic Owner(s): _____
6. Facility / Clinic Email: _____
7. Which CDSS member(s) (or agency) employs the dental hygienists, therapists, and assistants at this facility / clinic? _____
8. <u>Daily</u> in-house biological indicator (B.I.) tests be completed (including one <u>incubated</u> control B.I.) in each SK clinic with which you will be affiliated?

   _____
9. Will you have an <u>external</u> sterilizer monitoring service for <u>weekly</u> B.I. testing in each SK clinic with which you will be affiliated? YES ☐ NO ☐
10. Will you have a Radiation Health and Safety Manual in each SK clinic with which you will be affiliated? YES ☐ NO ☐
11. Will you have an ISO approved amalgam separator in each SK clinic with which you will be affiliated? YES ☐ NO ☐
12. I confirm that the dentist(s) and owner(s) of this facility / clinic are aware of and are compliant with CDSS Practice of Dentistry, Clinic Facility Standard sections 7 and 8, and CDSS Bylaws 3.8, 3.9 and 3.10. YES ☐ NO ☐
13. Does each CDSS member connected to, or practicing in, this facility / clinic have access to their patient records? YES ☐ NO ☐
14. I, as Clinic Director, agree to read, understand and communicate the CDSS Practice of Dentistry Clinic Facilities Standard to all staff within this facility/clinic before any DDAs23 authorized practice is performed to allow the practice of dentistry within this facility / clinic. I have emphasized the following:
    a. Advertising Standard YES ☐ NO ☐
    b. Sedation Standard YES ☐ NO ☐
    c. Workplace, Waste Management and Environmental Standard YES ☐ NO ☐
    d. Radiation Standard YES ☐ NO ☐
    e. Infection Prevention and Control Standard YES ☐ NO ☐
15. I understand that I must apply for **<u>Sedation Registration</u>** before any procedures involving sedation are performed in this facility / clinic and that each member performing sedation must have **<u>Sedation Registration</u>**. YES ☐ NO ☐
16. I understand that if general anesthesia will be performed by a CPSS licensed physician in this facility / clinic, that an inspection will be performed for accreditation as non-hospital treatment facility, pursuant to the Health Facilities Licensing Act. YES ☐ NO ☐

17. I agree to provide the CDSS with a **written protocol** for the continuity of care when any of the dentists practicing in the facility / clinic, take leave from, or discontinue their connection with this clinic (educational clinics exempted). YES ☐ NO ☐

18. I agree to **notify the CDSS within 24 hours of any changes** to the above information on this permit. YES ☐ NO ☐

Comprehensive Authorized Practice Director Name: _____ **Signature:** _____ **Date:** _____

****Comprehensive Authorized Practice Director**** means: the primary attending full practicing member, at a facility / clinic, will have the primary responsibility for the oversight of the comprehensive authorized practice carried on within that facility / clinic. This oversight includes:

(a) providing current practice contact information;
(b) acting as the most responsible member and contact at a facility / clinic for quality assurance purposes, in the public interest;
(c) the general safety of practice in the facility / clinic;
(d) reporting of critical incidents;
(e) the appropriate employment of, or contracting with, Assistants, Therapists and Hygienists;
(f) the supervision, which may vary depending upon circumstances, of comprehensive authorized practices performed at the facility / clinic pursuant to sections 15(2), and 23 of The Act, these bylaws and the CDSS Member Competence and Professional Practice Standard;
(g) obtaining required Facility / Clinic Registration and developing protocols regarding, but not limited to, Sedation and Anesthesia, Radiation and Imaging, Employment and Business Relationships, Agreements and Leases, Advertising, Quality Assurance, Patient Records and other legal requirements.;

Note: If you are solely a referral / consultant dentist, you are not an Authorized Practice Director unless it is part of your contract. Referral / consult dentists must list the organization contact information, but **not** all clinic sites.