



SDHA

Unit 320 – 350 3rd Ave N
Saskatoon, SK S7K 6G7

Saskatchewan Dental Hygienists' Association

306-931-7342
E-mail: sdha@sasktel.net

Office Use Only:
Date Received: _____
Date Approved: _____
SDHA Number: _____
CDHA Number: _____
License Type: _____
Approved by: _____

APPLICATION FOR REINSTATEMENT

November 2021 – October 2022

Please read Registration and Licensure Information for Applicants prior to completing this application. (www.sdha.ca)

Submit completed application form, required documents and fees to:
Saskatchewan Dental Hygienists' Association Unit 320 – 350 3rd Ave N, Saskatoon, SK S7K 6G7

Please allow 2-3 weeks for application processing.

For further information SDHA: 306-931-7342, ext 1 or Email: sdha@sasktel.net

I am applying for:	REGISTRATION	<input type="checkbox"/> Full Registration	OR	<input type="checkbox"/> Restricted Registration
	<u>AND</u> LICENSE	<input type="checkbox"/> Full License	<input type="checkbox"/> Conditional License	<input type="checkbox"/> Non-practicing License

1. Name	_____	_____	_____	_____
	Surname	First Name	Middle Name	Former Name or Other Surnames (List all-if applicable)
2. Address:	_____	_____	_____	_____
	Street	City	Province	Postal Code
3. Telephone	_____	_____	_____	_____
	Residence	Work	Mobile/Other	Email
4. Gender	<input type="checkbox"/> Female	5. CDHA Number: _____	6. Date of Birth: ____/____/____ (dd/mm/yyyy)	
	<input type="checkbox"/> Male			
7. Citizenship:	<input type="checkbox"/> Permanent Resident	Country _____	Work Permit: _____	
	<input type="checkbox"/> Temporary Resident			

8. GOOD STANDING TO PRACTICE DENTAL HYGIENE				
Please check one:				
<input type="checkbox"/> I have never been registered/licensed to practice dental hygiene in any other jurisdiction.				
OR				
<input type="checkbox"/> I have previously been <u>or</u> am currently registered/licensed to practice dental hygiene in another jurisdiction.				
LIST ANY/ALL JURISDICTION(S) WHERE YOU ARE CURRENTLY OR WERE PREVIOUSLY REGISTERED AS A DENTAL HYGIENIST				
Province or State: _____	Country _____	Year: _____	Registration No: _____	
Province or State: _____	Country _____	Year: _____	Registration No: _____	
<i>An original Letter of Good Standing must be mailed directly to the SDHA office from each previous and/or current jurisdiction(s) listed above.</i>				

9. SDHA HISTORY: Please indicate the following for the most recent year you were licensed to practice in Saskatchewan:		
Year: _____	SDHA Number: _____	Name (if different than current): _____

10. DENTAL HYGIENE EDUCATION: (Attach a notarized copy of your diploma)			
Credential	Name of Academic Institution	Graduation Month/Year	Full Name on Credential
<input type="checkbox"/> Diploma			
<input type="checkbox"/> Degree			

11. SUMMARY OF OTHER POST SECONDARY EDUCATION:			
Credential	Name of Academic Institution	Graduation Month/Year	Full Name on Credential

12. ADVANCED DENTAL HYGIENE KNOWLEDGE AND SKILLS:

Have you successfully completed a post-graduate dental hygiene module or graduated from a program of dental hygiene that offered any of the following? *(If you have completed a post-graduate Module, attach a copy of your Certificate of Completion)*

a. Administration of Local Anaesthetic Yes No Date Completed: _____
 Name of Institution: _____

b. Restorative Procedures Yes No Date Completed: _____
 Name of Institution: _____

c. Orthodontic Procedures Yes No Date Completed: _____
 Name of Institution: _____

13. EXAMINATIONS

National Dental Hygiene Certification Board (NDHCB)

I wrote the Canadian National Dental Hygiene Certification Board Examination (NDHCE) on ___/___/___ (dd/mm/yyyy) and the examination results are not yet available.

I passed the Canadian National Dental Hygiene Certification Board Examination (NDHCE) on ___/___/___ (dd/mm/yyyy) and am certified with the National Dental Hygiene Certification Board.

I have not yet attempted or passed the Canadian National Dental Hygiene Certification Board Examination.

Clinical Examination

If you graduated from a dental hygiene program that was **not** accredited by the **Canadian Commission on Dental Accreditation** you are required to complete a Clinical Examination approved by the SDHA. If applicable:

I have passed a Clinical Examination:

- On ___/___/___ (dd/mm/yyyy)
- At _____ (Name of Institution) in the province of _____.

If successfully completed, attach a notarized copy of your Clinical Examination Certificate or a letter from the Canadian jurisdiction where the Clinical Examination took place.

I have attempted a Clinical Examination and was unsuccessful.

- Date of Attempt(s):** 1: _____ 2: _____ 3: _____ 4: _____

I have never attempted a Clinical Examination in any Canadian jurisdiction.

14. LANGUAGE PROFICIENCY

Primary Language	<input type="checkbox"/> English	<input type="checkbox"/> French	<input type="checkbox"/> Other: _____
Language of your dental hygiene education	<input type="checkbox"/> English	<input type="checkbox"/> French	<input type="checkbox"/> Other: _____
Language in which you practice	<input type="checkbox"/> English	<input type="checkbox"/> French	<input type="checkbox"/> Other: _____
Language in which you completed the NDHCE	<input type="checkbox"/> English	<input type="checkbox"/> French	
English competency test completed:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> If yes, date completed: _____

15. CURRENT EMPLOYMENT STATUS

<input type="checkbox"/> Employed in Dental Hygiene	Not Employed and
<input type="checkbox"/> Seeking employment in dental hygiene	<input type="checkbox"/> Seeking employment in dental hygiene
<input type="checkbox"/> Employed in Another Field and	<input type="checkbox"/> Seeking employment in another field
<input type="checkbox"/> Seeking employment in dental hygiene	<input type="checkbox"/> On maternity leave
<input type="checkbox"/> Not seeking employment in dental hygiene	<input type="checkbox"/> On disability leave
	<input type="checkbox"/> Student
	<input type="checkbox"/> Retired
	<input type="checkbox"/> Other _____

16. EMPLOYMENT HISTORY

List dental hygiene employment for the most recent three (3) years, listing the most recent employer first. If space is insufficient, please attach a page. This information may be verified for accuracy.

Employed from: Month _____ Year _____	TO	Month _____ Year _____
Name of Employer: _____	Street Address: _____	
City, Town, Village: _____	Province: _____	Postal Code: _____ Business Telephone: _____ ()
Position	Practice Setting	Area of Responsibility
<input type="checkbox"/> Full-time permanent (>30 hours per wk)	<input type="checkbox"/> General dentistry	<input type="checkbox"/> Direct patient care
<input type="checkbox"/> Part-time permanent	<input type="checkbox"/> Specialty dentistry (specify) _____	<input type="checkbox"/> Administration
<input type="checkbox"/> Full-time temp/contract	<input type="checkbox"/> Community health	<input type="checkbox"/> Teaching
<input type="checkbox"/> Part-time temp/contract	<input type="checkbox"/> University/Technical Institute	<input type="checkbox"/> Research
Hours per Week: _____	<input type="checkbox"/> Hospital/ Long-term care facility	<input type="checkbox"/> Consulting
	<input type="checkbox"/> Other (specify) _____	<input type="checkbox"/> Other (specify) _____

Employed from: Month _____ Year _____	TO	Month _____ Year _____
Name of Employer: _____	Street Address: _____	
City, Town, Village: _____	Province: _____	Postal Code: _____ Business Telephone: _____ ()
Position	Practice Setting	Area of Responsibility
<input type="checkbox"/> Full-time permanent (>30 hours per wk)	<input type="checkbox"/> General dentistry	<input type="checkbox"/> Direct patient care
<input type="checkbox"/> Part-time permanent	<input type="checkbox"/> Specialty dentistry (specify) _____	<input type="checkbox"/> Administration
<input type="checkbox"/> Full-time temp/contract	<input type="checkbox"/> Community health	<input type="checkbox"/> Teaching
<input type="checkbox"/> Part-time temp/contract	<input type="checkbox"/> University/Technical Institute	<input type="checkbox"/> Research
Hours per Week: _____	<input type="checkbox"/> Hospital/ Long-term care facility	<input type="checkbox"/> Consulting
	<input type="checkbox"/> Other (specify) _____	<input type="checkbox"/> Other (specify) _____

Employed from: Month _____ Year _____ TO Month _____ Year _____			
Name of Employer:		Street Address:	
City, Town, Village:	Province:	Postal Code:	Business Telephone: ()
Position	Practice Setting	Area of Responsibility	
<input type="checkbox"/> Full-time permanent (>30 hours per wk)	<input type="checkbox"/> General dentistry	<input type="checkbox"/> Direct patient care	
<input type="checkbox"/> Part-time permanent	<input type="checkbox"/> Specialty dentistry (specify) _____	<input type="checkbox"/> Administration	
<input type="checkbox"/> Full-time temp/contract	<input type="checkbox"/> Community health	<input type="checkbox"/> Teaching	
<input type="checkbox"/> Part-time temp/contract	<input type="checkbox"/> University/Technical Institute	<input type="checkbox"/> Research	
Hours per Week: _____	<input type="checkbox"/> Hospital/ Long-term care facility	<input type="checkbox"/> Consulting	
	<input type="checkbox"/> Other (specify) _____	<input type="checkbox"/> Other (specify) _____	

17. SUMMARY OF PRACTICE HOURS					
Summary of practice hours in the most recent three years. Begin with the most recent year:	Year				Total Hours
		Hours			

GOOD CHARACTER and FITNESS TO PRACTICE	
18. Have you ever been convicted of a criminal offence in any jurisdiction? If yes, please explain: _____ _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
19. Has any registration or license entitling you to practise dental hygiene or any other health profession in any province, territory, state or country ever been limited, restricted, suspended or cancelled? If yes, please explain: _____ _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
20. Are you currently the subject of any reviews, investigations, disciplinary hearings or proceedings (including criminal proceedings) in any jurisdiction? If yes, please explain: _____ _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
21. Have you ever been denied registration or imposed conditions on your dental hygiene practice in another jurisdiction? If yes, please explain: _____ _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
22. Have you ever had a finding in the nature of professional misconduct, unskilled practice, incompetency or incapacity, or a like finding made against you as a student, dental hygienist or in a health profession other than dental hygiene? If yes, please explain: _____ _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
23. Do you have, or has anyone ever advised you that you have a physical, cognitive, mental and/or emotional condition which in any way may reasonably be expected to pose a risk of harm to patients or negatively impact your work as a dental hygienist? If yes, please explain:: _____ _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
24. Have you ever had, or have you ever been advised that you had, a physical, cognitive, mental and/or emotional condition which in any way, should it reoccur, may reasonably be expected to pose a risk of harm to patients or negatively impact your work as a dental hygienist? If yes, please explain: _____ _____	<input type="checkbox"/> Yes <input type="checkbox"/> No

You must not begin practice in Saskatchewan until you are registered and licensed with the SDHA. If you have arranged future employment as a dental hygienist in Saskatchewan, please indicate:

Name of Employer: _____ Street Address: _____

City/Town: _____ Postal Code _____ Business Phone _____ Projected Start Date _____

DECLARATION

I _____, of _____
(Print full name) (City, Town)

DO SOLEMNLY DECLARE THAT:

- I am the person applying for registration as a Registered Dental Hygienist in Saskatchewan;
- The information provided on this form and its attachment is correct, complete and true in every respect;
- I understand this declaration has the same significance as giving one under oath;
- I understand my application for registration and licensure may be refused, denied or cancelled if I have provided any inaccurate information;
- I understand that the information I have provided may be verified by the SDHA and I authorize the SDHA to seek additional information from third parties such as educational institutions, regulatory agencies, employers, or other sources as necessary in order to process my application and, I also authorize all such institutions, agencies or other sources to release such information to the SDHA;
- I understand that in order to practise dental hygiene in Saskatchewan, I am required by law to be registered and licensed with the SDHA, before I commence employment;
- If granted registration as a dental hygienist in the province of Saskatchewan, I will faithfully undertake to practice in accordance with provincial legislation, the Bylaws under The Dental Discipline Act, and established Competencies, Practice Standards, Code of Ethics and Continuing Competency Program Guidelines.

Signature: _____ Date: _____

As membership in the Canadian Dental Hygienists' Association (CDHA) is a requirement in Saskatchewan, this application form will also serve as your CDHA Membership Application. Your CDHA membership offers many benefits, one of which is your malpractice insurance coverage. In accordance with Section 49 of the SDHA Regulatory Bylaws, every dental hygienist holding a license to practice, must be insured against liability for negligence in an amount of at least one million dollars per occurrence.

If you are:

- ***An applicant who is already a member of CDHA in another province:*** You must apply for and pay the appropriate fees for a Full, Conditional or Non-practising License. The CDHA will be notified that you are dually registered in another province and they will reimburse any overpayment.

FEES:

Application Review Fee (NON-REFUNDABLE)	\$100.00	<input type="checkbox"/>
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AND

SDHA Reinstatement Fee	\$150.00	<input type="checkbox"/>
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AND - Choose one of the following:

Annual License Fee			
<ul style="list-style-type: none"> Full License: Qualified to administer local anaesthesia. 	SDHA License: \$600.00 CDHA Membership: \$216.00	\$816.00	<input type="checkbox"/>
<ul style="list-style-type: none"> Conditional License: Not qualified to administer local anaesthesia. License allowable for a maximum of two years from the initial registration date. 	SDHA License: \$600.00 CDHA Membership: \$216.00	\$816.00	<input type="checkbox"/>
<ul style="list-style-type: none"> Non-Practising License: Applicant must qualify for a Full or Conditional License and chose not to practice in Saskatchewan during the current licencing period. This type of License can be granted for a total of no more than three consecutive licencing periods (36 months). Continuing Competency Program requirements must be maintained. Applications in this category seeking to convert to a practicing License should seek the advice of the Registrar. 	SDHA License: \$330.00 CDHA Membership: \$ 99.00	\$429.00	<input type="checkbox"/>

CHECKLIST:

Attachments Required:

- Fees:
 - Application Review Fee - \$100.00 (Non-refundable)
 - Reinstatement Fee - \$150.00
 - Annual License Fee
- Notarized copy of dental hygiene diploma/degree (if not already on file)
- Notarized copy of National Dental Hygiene Certification Board Certificate (if not already on file)
- Successful completion of the SDHA Jurisprudence Education Module (JEM) within the past three years
- Notarized copy of Local Anaesthesia Certificate (Not applicable for SK Polytechnic Graduates) (if not already on file)
- Copy of government issued photo identification (Driver's License or Passport)

Additional Requirements for specific applicants:

- For applicants who have been registered/licensed in another jurisdiction***, an original Letter of Good Standing must be mailed directly to the SDHA office from each previous and/or current jurisdiction(s) listed above.
- For individuals not licensed in any jurisdiction, or have not practised for more than 36 months***, confirmation of a successful SDHA Council recognized currency program. Please contact the Registrar for guidelines/options to demonstrate currency of practice.