



SDHA

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

Saskatchewan Dental Hygienists' Association

306-931-7342
E-mail: admin@sdha.ca

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

APPLICATION FOR REINSTATEMENT

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: admin@sdha.ca

I am applying for:	REGISTRATION	<input type="checkbox"/> Full Registration	OR	<input type="checkbox"/> Restricted Registration
	AND 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 <input type="checkbox"/> Male <input type="checkbox"/> Other	5. CDHA Number: _____	6. Date of Birth: ____/____/____ (dd/mm/yyyy)	
7. Citizenship:	<input type="checkbox"/> Permanent Resident <input type="checkbox"/> Temporary Resident	Country _____	Work Permit: _____	

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 English French Other: _____

Language of your dental hygiene education English French Other: _____

Language in which you practice English French Other: _____

Language in which you completed the NDHCE English French

English competency test completed: Yes No If yes, date completed: _____

15. CURRENT EMPLOYMENT STATUS

<input type="checkbox"/> Employed in Dental Hygiene Employed in Another Field and <input type="checkbox"/> Seeking employment in dental hygiene <input type="checkbox"/> Not seeking employment in dental hygiene	Not Employed and <input type="checkbox"/> Seeking employment in dental hygiene <input type="checkbox"/> Seeking employment in another field <input type="checkbox"/> On maternity leave <input type="checkbox"/> On disability leave <input type="checkbox"/> Student <input type="checkbox"/> Retired <input type="checkbox"/> Other _____
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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: _____
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Position <input type="checkbox"/> Full-time permanent (>30 hours per wk) <input type="checkbox"/> Part-time permanent <input type="checkbox"/> Full-time temp/contract <input type="checkbox"/> Part-time temp/contract Hours per Week: _____	Practice Setting <input type="checkbox"/> General dentistry <input type="checkbox"/> Specialty dentistry (specify) _____ <input type="checkbox"/> Community health <input type="checkbox"/> University/Technical Institute <input type="checkbox"/> Hospital/ Long-term care facility <input type="checkbox"/> Other (specify) _____	Area of Responsibility <input type="checkbox"/> Direct patient care <input type="checkbox"/> Administration <input type="checkbox"/> Teaching <input type="checkbox"/> Research <input type="checkbox"/> Consulting <input type="checkbox"/> Other (specify) _____
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Employed from: Month _____ Year _____ TO Month _____ Year _____

Name of Employer: _____ Street Address: _____

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