



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)

Application for Reinstatement are handled on case-by-case basis. Additional information regarding your application may be required. If you have not held an active license in dental hygiene for a period of 36 months or longer. Please contact the SDHA Registrar at registrar@sdha.ca for approved refresher programs.

Submit completed application form by:
Email: admin@sdha.ca

Mail: Saskatchewan Dental Hygienists' Association
Unit 320 – 350 3rd Ave N, Saskatoon SK S7K 5G7

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. Date of Birth:	____/____/____ (dd/mm/yyyy)			
6. Citizenship:	<input type="checkbox"/> Permanent Resident <input type="checkbox"/> Temporary Resident			
	Country _____	Work Permit: _____		

7. 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: _____
An original Letter of Good Standing must be mailed directly to the SDHA office from each previous and/or current jurisdiction(s) listed above.

8. LIABILITY INSURANCE – Ensure a copy is attached with your application

Provider: _____ Policy #: _____ Expiry Date: _____

9. SUMMARY OF EVENTS SINCE LAST LICENSED WITH SDHA.

This information may be shared with the credentials committee in reviewing your application for Reinstatement.

Events may be included:

- Licensed in another jurisdiction(s)
- Leave from the profession
- Pursuit of other opportunities
- Break from profession for health reasons
- Family or personal reasons etc.

Please be descriptive as possible:

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. 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	
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<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) _____	
	<input type="checkbox"/>		

14. 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

15. Have you ever been convicted of a criminal offence in any jurisdiction? If yes, please explain: Yes
 No
16. 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: Yes
 No
17. Are you currently the subject of any reviews, investigations, disciplinary hearings or proceedings (including criminal proceedings) in any jurisdiction? If yes, please explain: Yes
 No
18. Have you ever been denied registration or imposed conditions on your dental hygiene practice in another jurisdiction? If yes, please explain: Yes
 No
19. 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: Yes
 No
20. 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: Yes
 No
21. 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: Yes
 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:

