Mailing Address
110 - 1765 8th Ave W
Vancouver, BC V6J 5C6

Main line: 672.202.0448
Toll free: 1.888.202.0448
registration@oralhealthbc.ca
www.oralhealthbc.ca

BCCOHP | British Columbia College of Oral Health Professionals

CERTIFIED DENTAL ASSISTANT – APPLICATION INSTRUCTIONS FOR TRANSFER TO FULL CERTIFIED DENTAL ASSISTANT

Contents

- Application for Transfer to Full Certified Dental Assistant

Checklist

- ☐ Have you answered all questions on the transfer form?
- ☐ Have you enclosed a copy of name change documents if your name has changed?
- ☐ Have you provided any supporting documents* required to transfer your certification?
- ☐ Have you signed the transfer form?

* To transfer your **Temporary Certification to Full**, notarized proof of successful completion of the NDAEB must be provided (ie. a notarized copy of NDAEB certificate, or a notarized copy of completion letter with certificate number from NDAEB).

* To transfer your **Limited Certification to Full Certification**, a proof of successful completion of additional skills must be provided.

NOTE: Please ensure you submit all required information. Incomplete information will delay the processing of your application. Incomplete applications may be returned.

Full Certification CDA Fees

Certification Fee for 1 March 2022 to 28 February 2023 (non-refundable after certification is granted)

If certification is finalized between 1 March – 31 August _____ C$155

Half year pro-ration if certification is finalized between 1 September – 28 February ____ C$83

Please indicate how you would like to pay by checking off the appropriate box below:

- ☐ By Credit Card – Once your application has been received and reviewed, you will receive an email notification to pay the certification fee online.
- ☐ By Cheque or Money Order – enclosed with application.

Please submit, by mail or courier, all completed forms, documents and fees (if not paying online) to:

BC College of Oral Health Professionals
110 - 1765 8th Ave W
Vancouver, BC V6J 5C6

***For reinstatement of lapsed certification (less than 60 days) reinstatement fee of $83 will be added to the invoice**

PLEASE RETURN THIS PAGE ALONG WITH THE APPLICATION.

BCCOHP | British Columbia College of Oral Health Professionals

APPLICATION FOR TRANSFER – TO FULL CERTIFIED DENTAL ASSISTANT

Current Certification Class – Select one only

☐ Limited Certification ☐ Temporary Certification ☐

Surname _____

Previous Surname (if applicable) _____

First _____ **Middle** _____

Preferred Name _____

Your name on the application must be the same as your current legal name. If the name you are applying with is different than the one on any of your supporting documents, you must provide a copy of legal documents certifying the name change (ie. marriage certificate, legal name change decree).

Date of birth – M/D/Y _____ **Gender** ☐ female ☐ male

BCCOHP Certification Number _____

Home

You must provide a valid home address and contact information, including an email address.

Address _____ Phone _____

City _____ Cell _____

Province _____ Postal Code _____

Main Email (for confidential information from BCCOHP) _____

Practice (if applicable)

Address _____ Phone _____

City _____ Province _____

Postal Code _____ Email _____

Privacy and Security

BCCOHP must collect and manage certain personal information to fulfill its regulatory purpose as set out in the *Health Professions Act* (the "*HPA*"). Additionally, BCCOHP is designated as a public body under the *Freedom of Information and Protection of Privacy Act (FOIPPA)*. BCCOHP collects and manages information in accordance with the *HPA, FOIPPA*, and other applicable laws.

Some of the information BCCOHP collects must be publicly accessible pursuant to the *HPA*. You may also wish for BCCOHP to provide your contact information to other professional organizations for the purposes stated. Please provide your instructions below:

Consent Levels for Release of Information

The *HPA* and the BCCOHP Bylaws require that certain information be included in the BCCOHP register and be publicly accessible. **Level 1** includes a list of the information which will appear in the register and on the BCCOHP web site. This is mandatory by law.

Level 1, below, is the minimum required however you may wish to allow for other use of your information as outlined below in Level 2 and Level 3. Please check one box below.

☐ **Level 1 (Minimum required by law)**

- Your name, class of certification and any additional qualifications recognized by BCCOHP which you have acquired and of which the Registrar has been notified; and
- Any limits or conditions placed on your entitlement to provide the services of a CDA, and any notations or revocation or suspensions on your certification.

☐ **Level 2**

This consent level, in addition to **Level 1**, allows for personal contact information to only be released and used by BCCOHP and the Certified Dental Association of British Columbia (CDABC).

☐ **Level 3**

This consent level, in addition to **Levels 1 & 2**, allows for personal contact information (mailing address) to be released to selected third parties for professional purposes only.

- Professional purposes may include CE opportunities, dental conferences, and information from component societies.
- This does not include commercial enterprises providing products or services.

Authorization and Oath

- I am applying to be certified as a full certified dental assistant with the BC College of Oral Health Professionals ("BCCOHP") pursuant to the Bylaws made under the *Health Professions Act* (the *"HPA"*). In consideration of BCCOHP's processing of my application, by my signature below, I authorize BCCOHP to make reasonable and lawful enquiries about me, including enquiries seeking confidential or personal information (in documentary form or otherwise) from any regulatory authority, hospital, educational program, institution or law enforcement agency (collectively, the "Certification-Related Information"), and to then consider and use the Certification-Related Information, all for the sole purpose of determining my fitness for certification as a full certified dental assistant in British Columbia.
- I have read and understood BCCOHP's *Standards and Guidance documents*, including the *Code of Ethics*, which facilitate the delivery of competent and ethical patient-centred care. I understand that I am responsible for applying these standards and guidelines in my practice.
- I acknowledge and understand that in order to practise safely, I must be both competent and fit to practise. Competent – in that I have the requisite knowledge, skills and experience. Fit to practise – in that I am not impaired by some physical, mental or addiction issue that affects my ability.
- I recognize that those who, in good faith, furnish Certification-Related Information to BCCOHP in connection with my application for certification have reasonable expectations that such Certification-Related Information will be kept confidential.
- I further understand that BCCOHP may take disciplinary action against me, including action to revoke my certification, if I have, by omission or commission, knowingly given false or misleading information in the course of completing this application for registration.

Signature _____ **Date** – M/D/Y _____

MAKE SURE YOU HAVE SIGNED THIS FORM.