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 INSTRUCTIONS FOR APPLICATION FOR TRANSFER – NON-PRACTISING TO FULL CERTIFICATION

This application package is for Non-practising Certified Dental Assistants who meet the following Quality Assurance (QA) Requirements:

- a minimum of 600 hours of continuous practice* in the preceding three years, and
- your continuing education cycle must be current

*Acceptable continuous practice activities include the provision of clinical dental treatment, employment as a dental educator, or full-time enrollment in a dental education program.

Note – Supporting documentation of continuous practice is not required, but may be requested.

If you do not meet the QA requirements, please contact BCCOHP for further information.

Contents

- Application for Transfer from Non-Practising to Full Certified Dental Assistant

Checklist

☐ Have you answered all the questions on the application form?

☐ If certified/licensed in another jurisdiction, have you requested a Letter of Standing from that licensing or regulatory authority?

☐ Have you signed your application?

Full Certification Fees

If certification is finalized between 1 March – 31 August ______ C$97*

If certification is finalized between 1 September – 28 February ______ C$25*

* Includes transfer fee

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 transfer and certification fees 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

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

PLEASE RETURN THIS PAGE ALONG WITH THE APPLICATION.

BCCOHP | British Columbia College of Oral Health Professionals

CERTIFIED DENTAL ASSISTANT – APPLICATION FOR TRANSFER FROM NON-PRACTISING TO FULL CERTIFICATION

Surname ______________________________

Previous Surname (if applicable) ______________________________

First ____________________ **Middle** ____________________

Preferred Name ______________________________

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

Place of birth – City/Province/Country ______________________________

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

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 consent level for release of information.

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.

Have you been or are you licensed/registered/certified elsewhere as a healthcare provider?

☐ Yes ☐ No If yes, complete the following:

Jurisdiction	Address	Time Period From M/D/Y – M/D/Y

Are you practising elsewhere as a healthcare provider?

☐ Yes ☐ No If yes, an original letter or certificate of standing must be sent directly to BCCOHP from that regulatory/licensing organization.

IMPORTANT: If you are or have ever been certified/licensed in another province or country, you will be required to contact that provincial or national regulatory body to request a Certificate or Letter of Standing for your BCCOHP application. The Certificate or Letter of Standing must be delivered directly to BCCOHP from the licensing/regulating body in a sealed envelope.

The Certificate or Letter of Standing is valid for up to 60 days from the date that it was issued. If an applicant does not have their registration/certification process completed within 60 days from the date of issue, a new Certificate or Letter of Standing will be required.

Quality Assurance Requirement

Have you engaged in the practice of dental assisting in another jurisdiction over the preceding three years?

☐ Yes ☐ No

If yes, where? ____________________

If yes, please provide information on Continuous Practice hours and Continuing Education credits.

Continuous Practice

Please provide number of continuous practice as a licensed/regulated dental healthcare provider (defined as 600 hours over the preceding three years).

Practice hours in 20____: [ ] 20____: [ ] 20____: [ ]

Indicate specific number of hours, e.g. 500.

Note: Acceptable continuous practice activities include the provision of clinical dental treatment, employment as a dental educator, or full-time enrollment in a dental education program.

Continuing Education

Please attach a copy of your current continuing education transcript from any other regulatory/licensing body if applicable indicating that you have met the requirements of that body (defined as 36 credits over the preceding three years).

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 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.