Ordre des dentistes du Québec

APPLICATION FORM:
LICENSE TO PRACTICE OR CERTIFICATE OF SPECIALIST

Application for a registration in the Month/Year: _____

TYPE OF LICENSE OR CERTIFICATE REQUESTED

Note: A separate application form is required for each type of license, certificate or registration.

☐ GENERAL ☐ SPECIALITY _____ (specify) ☐ RESTRICTIVE/TEMPORARY _____ (specify) ☐ REINSTATEMENT

Applicant Name		
LAST	GIVEN NAMES	
CURRENT PROFESSIONAL ADDRESS: STREET	SUITE	CITY
PROVINCE/STATE	POSTAL CODE	TEL / FAX / E-MAIL
HOME ADDRESS: STREET	SUITE	CITY
PROVINCE/STATE	POSTAL CODE	TEL / FAX / E-MAIL
DATE OF BIRTH MONTH/DAY/YEAR / /		PLACE OF BIRTH
GENDER: ☐ MALE ☐ FEMALE		FLUENT IN: ☐ ENGLISH ☐ FRENCH ☐ OTHER

Please provide a certified copy of your birth certificate. You will be requested to present one of the following documents for identity verification purposes to the person in charge of admission: driver's license, health insurance card or passport.

Is the name on your birth certificate or diploma different from the one above? YES ☐ NO ☐

Please provide details: _____

Date of Name Change: _____ Location: _____

Please provide a certified copy of any legal document certifying name change, i.e. Marriage Certificate, Legal Name Change Decree, etc.

FOR OFFICE USE ONLY

Date received: _____ Approved by: _____

License number: _____ Issue date: _____

LE DENTISTE,
LE DOCTEUR QUI VEILLE
SUR VOTRE BOUCHE

800, boulevard René-Lévesque Ouest
Bureau 1640
Montréal (Québec) H3B 1X9

TÉLÉPHONE : **514 875-8511** | 1 800 361-4887
TÉLÉCOPIEUR : 514 393-9248
SITE WEB : **www.odq.qc.ca**

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PHOTO:

Please provide a passport-sized photo taken within the past six months, sign in the space indicated and have a witness sign on the back to attest authenticity.

YOUR SIGNATURE

Knowledge of the French Language

Have you received full time secondary or post-secondary instruction in French for at least three years?

☐ yes ☐ no

If yes, attach a copy of certificate.

Have you passed the fourth or fifth year secondary level examinations in French as the first language?

☐ yes ☐ no

If yes, attach a copy of certificate.

Have you obtained a secondary school certificate (High School Diploma) in Quebec since 1986?

☐ yes ☐ no

If yes, attach a copy of certificate.

Have you obtained a certificate issued by the Office québécois de la langue française or do you hold a certificate defined as equivalent by regulation of the Government?

☐ yes ☐ no

If yes, attach a copy certificate.

PRE-DENTAL EDUCATION

NAME OF COLLEGE OR UNIVERSITY / LOCATION	DIPLOMA / DEGREE	DATE STARTED	DATE COMPLETED
		mm / dd / yy	mm / dd / yy
		mm / dd / yy	mm / dd / yy

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DENTAL EDUCATION

NAME OF UNIVERSITY/LOCATION	DIPLOMA/DEGREE	DATE STARTED	DATE COMPLETED
		mm/dd/yy	mm/dd/yy
		mm/dd/yy	mm/dd/yy

Please provide a certified photocopy of your diploma in dentistry or, in the case of new graduates, an original letter from the Dean or his/her designate certifying your graduation in dentistry. Note: If reinstating, it is not necessary to forward this documentation again.

NDEB CERTIFICATE

Do you have a certificate issued by the National Dental Examining Board of Canada? ☐ YES ☐ NO

If yes, please provide a certified copy and write down number here _____.

Has there been a period of five years or more since you obtained your NDEB certificate during which you did not engage in the practice of dentistry on a continuous and regular basis either in Canada or the United States? ☐ YES ☐ NO

POST GRAD EDUCATION (INTERNSHIP OR SPECIALTY PROGRAM)

NAME OF UNIVERSITY/LOCATION	DIPLOMA/DEGREE	DATE STARTED	DATE COMPLETED
		mm/dd/yy	mm/dd/yy
		mm/dd/yy	mm/dd/yy

Please provide a certified photocopy of your post graduation diploma (internship or specialty program) or, in the case of new graduates, an original letter from the Dean or Director of postgraduate studies or his/her designate (internship or specialty program) certifying your graduation in your postgraduate dental program . Note: If reinstating, it is not necessary to forward this documentation again.

POST GRAD EDUCATION (NDSE)

Have you passed the Royal College of Dentists of Canada Specialty Examination: ☐ YES ☐ NO

Date: _____ Specialty: _____

If "yes", please have the RCDC forward a letter to us verifying your successful completion.

Since completing either an accredited specialty program (Canada or the United States) or having been assessed and obtained a Certificate of Completion from an approved Canadian University, has there been a period of five years or more during which you did not engage in the specialty practice of dentistry on a continuous and regular basis either in Canada or the United States?

☐ YES ☐ NO

JURISPRUDENCE & ETHICS COURSE

Have you taken a Jurisprudence and Ethics Course? ☐ YES ☐ NO

Location and Date: _____

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PRACTICE INFORMATION

Have you practised or been previously registered/licensed to practise dentistry (or any profession) in any jurisdiction / country / province / state?

☐ YES (FILL OUT ATTACHED FORM A) ☐ NO

If "yes", check the form of registration/license you held and list all of the locations at which you have practiced or where registered/licensed. Attach a separate list if required.

☐ (i) a General Certificate/Licence from _____ (M/D/Y) to _____ (current or M/D/Y)..

☐ (ii) a Specialty Certificate/Licence in _____(specify specialty) from _____ to _____(current or M/D/Y).

☐ (iii) an Education Certificate/Licence (Residency/Internship) from _____ to _____(current or M/D/Y).

☐ (iv) a Graduate Certificate/Licence (Student) from _____ to _____(current or M/D/Y) .

☐ (v) an Academic Certificate/Licence (Professor) from _____ to _____(current or M/D/Y).

☐ (vi) other: _____ from _____(M/D/Y) to _____(current or M/D/Y).

Country/Province or State/Region	REGISTERED/LICENSED	
	From (M/D/Y)	To (M/D/Y)

If you have practised or been previously registered/licensed to practise dentistry (or any profession) then you must have each regulatory body concerned complete our Certificate of Standing (even if you did not practice). Please complete release (Form A) so that we may obtain additional information from the regulatory body should we determine it appropriate to do so.

Active practice of dental medicine

Have you actively practised dental medicine in the past five years?

☐ YES (please provide work attestations) ☐ NO

If you have not actively practised dental medicine in the past five years, the *Regulation respecting refresher training periods for dentists*, RRQ, c. D-3, r.15, will apply.

PAST JUDICIAL AND PROFESSIONAL CONDUCT

If you have engaged in the practise of dentistry or any profession in any jurisdiction, have you ever been the subject of any proceedings referable to your competence (professional misconduct or incompetence) or fitness to practise (incapacity)?

☐ YES ☐ NO

If "yes", please provide full details including copies of any documents in your possession referable to the matter. Attach a separate record if there is insufficient space in the box below.

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Have you ever been the subject of a judiciary decision finding you guilty of a criminal or penal offence in a Canadian or foreign court?

☐ YES ☐ NO

If "yes", please provide full details including copies of any documents in your possession referable to the matter. Attach a separate record if there is insufficient space in the box below.

Have you ever been refused registration/licensure in any jurisdiction?

☐ YES ☐ NO

If "yes", please provide full details including copies of any documents in your possession referable to the matter. Attach a separate record if there is insufficient space in the box below.

HEALTH HISTORY

Do you currently suffer from any physical or mental condition or disorder (including alcohol or drug addiction) which may impair your ability to practise dentistry safely and competently or which, if left untreated, would impair your ability to practise dentistry safely and competently?

☐ YES (FILL OUT FORM B) ☐ NO

Have you in the past suffered from a physical or mental condition or disorder (including alcohol or drug addiction) which has impaired your ability to practise dentistry safely and competently or which, if left untreated, would have impaired your ability to practise dentistry safely and competently?

☐ YES (FILL OUT FORM B) ☐ NO

If your answer to either of the above two questions is "yes", please provide full details including a certificate of your attending physician confirming the diagnosis and your current state of health. Attach a separate record if there is insufficient space in the box below.
Also provide a separate release (Form B) so that we may obtain information directly from your attending physician.

If you are a carrier of a blood-borne virus, you are admissible to the services of the Blood-borne Infection Risk Assessment Unit of the Institut national de santé publique du Québec (SERTIH) whose mandate is endorsed by the Ordre in its Position Statement of February 2005 entitled Bloodborne Infections and Public Protection. Please refer to the SERTIH or the Ordre's web site on this matter. Since the Ordre processes this information confidentially, it is advised that you communicate directly with the Administration Office.

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DECLARATION AND SOLEMN AFFIRMATION

I solemnly declare and affirm that the contents of this application are true and complete to the best of my knowledge and belief. I understand and agree that if I make a false or misleading statement or representation in respect of my application or submit falsified documentation, I shall be deemed not to have satisfied the requirements for a license or certificate. I further understand and agree that if a license or certificate should be issued to me based upon a false or misleading statement, representation or documentation, then the license or certificate will be subject to immediate revocation/cancellation.

Taken and declared before me in the District, Province, State of

This _____day of_____, 20_____.

_____

Judge, Notary Public, Lawyer, or other person authorized to administer the oath

(Official seal, stamp, or business card must be provided.)

_____

Signature of Applicant

N.B. A certified translation of documents written in a language other than French or English is required.

(This application is valid for 3 months from the date of signing/attestation.)

Ordre des dentistes du Québec

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FORM A Consent allowing the collection of information for registration or reinstatement purposes Complete if answer to Practice Information is "yes"	I have made application with the Ordre des dentistes du Québec for a license or certificate of specialty / registration in order to engage in the practice of dentistry in Québec. The Ordre may wish additional information in connection with my application. I therefore authorize and direct the following professional regulatory body[1], namely_____ to provide the Ordre des dentistes du Québec, at my expense, with full disclosure of any and all information or document it may have respecting my application as well as my registration and practice in the province or territory of _____. I understand that this information is necessary for the exercise of the rights and powers of the Ordre des dentistes du Québec with respect to the processing of my application for a license or certificate of specialty / registration as well as to my professional file thereafter. _____ _____ Signature of Applicant Date
FORM B Consent allowing the collection of medical information for registration or reinstatement purposes Complete if answer to Health History is "yes"	I have made application with the Ordre des dentistes du Québec for a license or certificate of specialty / registration in order to engage in the practice of dentistry in Québec. The Ordre may wish additional information in connection with my application. I, therefore, authorize and direct the following attending physician[2], namely _____ to provide the Ordre des dentistes du Québec, at my expense, with full disclosure of any and all information or document he / she may have respecting my current or past state of health and more particularly with the diagnosis of _____. I understand that this information is necessary for the exercise of the rights and powers of the Ordre des dentistes du Québec with respect to the processing of my application for a license or certificate of specialty / registration as well as to my professional file thereafter. _____ _____ Signature of Applicant Date

[1] Make additional copies of Form A if more than one regulatory body is involved.
[2] Make additional copies of Form B if more than one physician is involved.