

College of Registered Dental Hygienists of Alberta

Suite 302, 8657- 51 Avenue, Edmonton AB T6E 6A8 ♦ Phone: 780-465-1756 or Toll Free 877-465-1756 Fax: 780-440-0544

APPLICATION FOR RENEWAL

For Use By Persons on the Non-Practicing Membership Register for the Year Ending October 31, 2017

Please provide the required information below

CRDHA Reg #:

Name:

Address:

Home Phone:

Cell Phone:

Email:

2017-2018 Renewal Category	Fees
<input type="checkbox"/> 1. Non-Practicing Membership Non-Regulated Members Register Not entitled to practice dental hygiene Not entitled to use protected titles Includes CDHA Support membership	\$210.00
<input type="checkbox"/> 2. Transfer to the General Register Refer to transfer policy requirements Pay \$852.00 if you <u>do not have</u> liability insurance coverage to December 31, 2017.	\$852.00
OR	
Pay \$799.00 and attach proof of \$1M liability insurance coverage to December 31, 2017. If transfer is approved, you will receive a Practice Permit, CRDHA General Registration and CDHA Plan 1 - \$1M liability insurance.	\$799.00
<input type="checkbox"/> 3. Cancellation of Registration **Must sign request area at bottom of page 4	N/C
<input type="checkbox"/> 4. Late Payment Penalty (Non-Practicing) Late payment penalty must be enclosed with payments that will be received by CRDHA after October 31.	\$ 23.00
Total Amount Paid	\$

NOTE: Due to privacy and security issues, credit card payments can only be accepted with online renewals.

Completed renewal application and payment in full for Non-Practicing membership must be received by CRDHA **on or before Tuesday, October 31, 2017.**

If applying for Transfer to the General Register, completed renewal form and payment in full must be received by CRDHA **on or before Tuesday, October 10, 2017** in order to confirm that all requirements for transfer have been met and to generate a Practice Permit for November 1, 2017.

For Office Use Only

Deposit Date:	Receipt No.:
Batch No.:	

Employment Status on October 1, 2017 - select one box only	
Employed in Dental Hygiene <input type="checkbox"/> 1. On October 1, 2017	Not employed and <input type="checkbox"/> 4. Seeking employment in D.H. <input type="checkbox"/> 5. Seeking employment in another field <input type="checkbox"/> 6. On maternity leave <input type="checkbox"/> 7. On disability leave <input type="checkbox"/> 8. Student <input type="checkbox"/> 9. Retired <input type="checkbox"/> 10. Other reasons
Employed in Another Field and <input type="checkbox"/> 2. Seeking employment in dental hygiene <input type="checkbox"/> 3. Not seeking employment in dental hygiene	

Total number of years of work experience in dental hygiene practice: _____ years

Retired: Year _____ Intention to retire: Year _____ Not applicable at this time

If you are applying for transfer to the General Register, you must not begin to practice dental hygiene until a Practice Permit has been issued. However, if you have arranged future employment as a dental hygienist please provide the following information.

Primary Place of Employment (location where the most hours will be worked)

Name of Employer			Business Name & Street Address	
City, Town, Village	Province	Postal Code	Business Telephone ()	Projected start date
Current Position <input type="checkbox"/> 1. Full-time permanent (30 hrs. or more per week) <input type="checkbox"/> 2. Part-time permanent <input type="checkbox"/> 3. Full-time temp/contract <input type="checkbox"/> 4. Part-time temp/contract	Practice Setting <input type="checkbox"/> 1. General dentistry <input type="checkbox"/> 2. Specialty dentistry (specify) _____ <input type="checkbox"/> 3. Community health <input type="checkbox"/> 4. University/Technical Institute <input type="checkbox"/> 5. Hospital <input type="checkbox"/> 6. Other (specify) _____ <input type="checkbox"/> 7. Independent DH Practice	Primary Area of Responsibility <input type="checkbox"/> 1. Direct patient care <input type="checkbox"/> 2. Administration <input type="checkbox"/> 3. Teaching <input type="checkbox"/> 4. Research <input type="checkbox"/> 5. Consulting <input type="checkbox"/> 6. Other (specify) _____		

Second Place of Employment

Name of Employer			Business Name & Street Address	
City, Town, Village	Province	Postal Code	Business Telephone ()	Projected start date
Current Position <input type="checkbox"/> 1. Full-time permanent (30 hrs. or more per week) <input type="checkbox"/> 2. Part-time permanent <input type="checkbox"/> 3. Full-time temp/contract <input type="checkbox"/> 4. Part-time temp/contract	Practice Setting <input type="checkbox"/> 1. General dentistry <input type="checkbox"/> 2. Specialty dentistry (specify) _____ <input type="checkbox"/> 3. Community health <input type="checkbox"/> 4. University/Technical Institute <input type="checkbox"/> 5. Hospital <input type="checkbox"/> 6. Other (specify) _____ <input type="checkbox"/> 7. Independent DH Practice	Primary Area of Responsibility <input type="checkbox"/> 1. Direct patient care <input type="checkbox"/> 2. Administration <input type="checkbox"/> 3. Teaching <input type="checkbox"/> 4. Research <input type="checkbox"/> 5. Consulting <input type="checkbox"/> 6. Other (specify) _____		

Third Place of Employment

Name of Employer			Business Name & Street Address	
City, Town, Village	Province	Postal Code	Business Telephone ()	Projected start date
Current Position <input type="checkbox"/> 1. Full-time permanent (30 hrs. or more per week) <input type="checkbox"/> 2. Part-time permanent <input type="checkbox"/> 3. Full-time temp/contract <input type="checkbox"/> 4. Part-time temp/contract	Practice Setting <input type="checkbox"/> 1. General dentistry <input type="checkbox"/> 2. Specialty dentistry (specify) _____ <input type="checkbox"/> 3. Community health <input type="checkbox"/> 4. University/Technical Institute <input type="checkbox"/> 5. Hospital <input type="checkbox"/> 6. Other (specify) _____ <input type="checkbox"/> 7. Independent DH Practice	Primary Area of Responsibility <input type="checkbox"/> 1. Direct patient care <input type="checkbox"/> 2. Administration <input type="checkbox"/> 3. Teaching <input type="checkbox"/> 4. Research <input type="checkbox"/> 5. Consulting <input type="checkbox"/> 6. Other (specify) _____		

Update of Recent Educational Achievements

Has a new diploma or degree been awarded since you last renewed your CRDHA membership?

No Yes Date Awarded: _____

If yes, Diploma/Degree Title: _____

Specializing in : 1. Teaching 4. Management/Administration
 2. Research 5. Other (please specify)
 3. Community Health/Hospital

Name of Institution: _____

Address of Institution: _____

Update of Advanced Dental Hygiene Knowledge and Skills

In the past year, have you completed a comprehensive post-diploma/degree dental hygiene module or continuing education program which included didactic and clinical education in any of the areas listed below? **Please contact the CRDHA office immediately if you have not already completed an application for authorization to perform these activities.**

1. Administration of Local Anaesthetic No Yes
 Institute: _____ Province/State: _____ Year _____

2. Administration of Nitrous Oxide No Yes
 Institute: _____ Province/State: _____ Year _____

3. Restorative Procedures No Yes
 Institute: _____ Province/State: _____ Year _____

4. Orthodontic Procedures No Yes
 Institute: _____ Province/State: _____ Year _____

5. Other (please describe) No Yes

 Institute: _____ Province/State: _____ Year _____

List Jurisdictions Where You Are Currently or Were Previously Registered/Licensed to Practice Dental Hygiene or Any Other Health Profession

Name of Regulatory Body	Province / State and Country	Registration/License #	Expiry Date

Good Character & Fitness to Practice

- 1. Has any registration or license entitling you to practice dental hygiene or any other health profession in any province, territory, state, or country ever been denied, limited, restricted, suspended, or cancelled? Yes No
- 2. Have you ever had a finding in the nature of professional misconduct, unskilled practice, incompetency, or incapacity, or a like finding, made against you either in Alberta or elsewhere as a dental hygienist or in a health profession other than dental hygiene? Yes No
- 3. Are you currently the subject of any reviews, investigations, disciplinary hearings, or proceedings (including criminal proceedings) in any jurisdiction? Yes No
- 4. Have you ever been convicted of a criminal offense in any jurisdiction? Yes No
- 5. Are you affected by a physical, mental, or emotional condition or disorder that may impair your ability to provide dental hygiene services in a safe and competent manner? (Includes HBV, HCV & HIV) Yes No
- 6. Are you affected by an addiction to alcohol, drugs, or other chemicals that may impair your ability to provide dental hygiene services in a safe and competent manner? Yes No

If you answered "yes" to ANY question above, provide a brief narrative. You may also be required to provide further documentation.

Renewal Declaration Statement

I, _____, certify to the best of my knowledge that the information provided on this form and any attachments is complete and true, and knowing that it is of the same force and effect as if made under oath and by virtue of the "Canada Evidence Act". I understand that making a false statement on this application could result in the rejection of the application. I understand that Non-Practicing Members are not authorized to practice dental hygiene or use the protected titles "dental hygienist", "registered dental hygienist", "DH", or "RDH".

I authorize the CRDHA to seek additional information from educational institutions, regulatory agencies, employers, or other sources as necessary in order to process my application for renewal of membership; and I also authorize all such institutions, agencies, employers, or other sources to release such information to the CRDHA and for so doing let this be your good and sufficient authority.

Signature: _____ Date: _____

Cancellation by Request

Please cancel my registration. I understand that this request will cause my name to be struck from the CRDHA Register. I understand that cancelled members are not authorized to practice dental hygiene or use the protected titles "dental hygienist", "registered dental hygienist", "DH", or "RDH". I also understand that if I apply for reinstatement of registration with the CRDHA I will be required to meet the same requirements for registration as any other new registrant, including payment of fees and the completion of any required written and/or clinical professional examinations.

Signature: _____ Date: _____