



**Consent to Request and Release of
Vulnerable Sector and Criminal Record Search**

(To be provided to the CDSA)

Legal Name: _____
(First Name) (Middle Name(s)) (Last Name)

Below are any former or other names I have used or are currently using:

1. _____
(First Name) (Middle Name) (Last Name)
2. _____
(First Name) (Middle Name) (Last Name)

I consent to a member of a police force or other authorized body to conduct a vulnerable sector criminal record search based on the above represented names and to provide the results. This search and results are necessary to apply to be registered as a dentist in Alberta by the College of Dental Surgeons of Alberta.

I understand that this means I am consenting in writing to a member of a police force or other authorized body to verify whether I am the subject of a notation made in accordance with section 6.3(2) of the *Criminal Records Act* (Canada).

Section 6.3(2) of the *Criminal Records Act* (Canada) outlines:

The Commissioner shall make, in the automated criminal conviction records retrieval system maintained by the Royal Canadian Mounted Police, a notation enabling a member of a police force or other authorized body to determine whether there is a record of an individual's conviction for an offence listed in Schedule 2 in response of which a record of suspension has been ordered.

I understand that the College of Dental Surgeons of Alberta requires a criminal record check, that includes a vulnerable sector check, as part of my application to be registered as a dentist in Alberta. I further understand that the College of Dental Surgeons of Alberta will review and use the results of the criminal record check and the vulnerable sector check to determine if I meet the requirements of registration. The details of the criminal record check and the vulnerable sector check may result in my application for registration being refused. If my application is refused, I understand that I will be notified in writing with reasons for the application refusal and appeal process.

I understand that it is my decision to provide the results of the searches to the College of Dental Surgeons of Alberta. If I do not provide the results, my application will be incomplete, and I will not be registered in Alberta.

By signing this consent form below, I confirm that I have accurately and truthfully represented my name and names, if applicable, and understand the content, meaning and effect of this consent. I understand and agree that if I make a false or misleading statement or representation with respect to my application, I will be deemed to have not satisfied the requirements to register as a dentist in Alberta. I also understand and agree that if a Practice Permit Certificate is issued based on false or misleading information that I provided, the Practice Permit Certificate will be immediately cancelled.

Signature of Applicant

Date