College of Dental Surgeons of Alberta

SUPPORTIVE PATHWAY TO NDEB CERTIFICATION IN ALBERTA
INTERNATIONALLY TRAINED DENTIST APPLICATION

An email confirmation of receipt upon review of the application will be forwarded. Any additional information required will be outlined by email to the applicant.

Application Preparation

The following information must be emailed to the CDSA directly from the source:

☐ Official transcripts from each post-secondary institution related to dental education.
- Applicants must request their transcripts to be sent directly from the educational institution to the CDSA
- Transcripts must list courses taken, grades obtained, and if applicable to that educational institution, the degree or diploma awarded
- Documents not in English must be accompanied by certified translations
- Undergraduate transcripts are not required

☐ Certificates of Good Standing (if applicable)
- If currently **or** previously registered in any Canadian province
    - This is to include from any other dental professions currently or previously registered with (i.e, Hygienist, Assistant, etc.)
    - Certificates of Standing are valid for 8 weeks from the date they are issued
    - The applicant is responsible for ensuring this information is current
    - The Certificate of Standing must be emailed directly to the CDSA from each regulatory body in which the applicant is/was registered. Certificates of Standing sent by the applicant will not be accepted
    - The applicant is responsible for ensuring this information is current

☐ Letter of Good Standing (if applicable)
- If currently or previously registered in the U.S.A. or Internationally
- This is to include from any other dental professions currently or previously registered with (i.e, Hygienist, Assistant, etc.)
- The letter must be emailed directly to the CDSA from each regulatory body in which the applicant is/was registered. Letters of Good Standing sent by the applicant will not be accepted
- Letters of Good Standing are valid for 8 weeks from the date they are issued
- The applicant is responsible for ensuring this information is current

Additional Documents required by the applicant:

☐ A description of your relevant clinical and academic experience

☐ English Language Proficiency Documentation

☐ Proof of current HCP/CPR including AED

☐ A Notarized or Certified copy of Canadian government issued photo identification

☐ Consent to Share Information from NDEB to Supportive Pathway Program at CDSA

The submitted information will be evaluated by the Registrar of the CDSA.

Credential Review

The following information must be supplied to the CDSA by the applicant. All documents must be clear and readable.

1. Please provide a copy of the following:
   - Notarized or Certified copy of Canadian government issued photo identification
     - Passport, citizenship card, or proof of permanent residency status
     - Or a certified copy of the authorization issued by Citizenship and Immigration Canada of a person lawfully permitted to work in Canada

   - Statutory Declaration
     - Must be completed and signed by a Notary Public or Commissioner for Oaths

   - Notarized or Certified copy of dental degree(s) or diploma(s) earned
     - Testimurs are not accepted

   - Criminal Record Check and Vulnerable Sector Check from within the last 12 months
   - Criminal Record Check and Vulnerable Sector Check Consent form

   - Proof of current Basic Life Support (HCP/CPR including AED) or equivalent certification within the last 12 months

   - Consent for Release of Information form(s) for a jurisdiction in which the applicant is/was registered to practice dentistry

   - Approved application to the NDEB Equivalency Process
     - Successful completion of the Assessment of Fundamental Knowledge (AFK)
     - Successful completion of the Assessment of Clinical Judgement (ACJ) within the last three (3) years

2. Any other information requested by the Registrar
3. Application Fee

Contact Information

The CDSA is governed by the *Health Professions Act*. CDSA bylaws require a valid email address specific to the applicant for the purpose of receiving communications from the College.

Name: First Name Middle Name(s) Surname

Preferred display name: _____

Is this name different from the one on your Degree(s)/Certificate(s): No

If yes, the name displayed is: _____

☐ If yes, a copy of legal documents of name change is attached.
(*i.e. marriage certificate or legal name change decree*)

Home Address:

_____

_____
(City) Province/State (Postal/ZIP Code)

_____ _____
(Home Phone Number) (Cell Phone Number)

_____
(Email Address)

Work Address: (if applicable) ☐ I do not currently have a work address.

_____

_____
(City) Province/State (Postal/ZIP Code)

_____ _____
(Home Phone Number) (Cell Phone Number)

_____
(Email Address)

I wish to receive mail from CDSA

- ○ At my home address
- ○ At my work address

Personal Information

Place of Birth: _____ Date of Birth: _____
YYYY-MM-DD

Additional language(s) spoken
As a courtesy to the public, this information will be provided within your listing on the online Registrant Lookup.

_____ _____
_____ _____

☐ A Notarized or Certified copy of government issued photo identification is attached.

Statuatory Declaration
The Statutory Declaration must be completed and notarized by a Notary Public or Commissioner for Oaths. (*Attached*)

☐ This signed document is attached.

Consent to Share Information from NDEB to the CDSA

I understand my consent is required:

1. To share my application information with NDEB for verification purposes
2. To grant permission to the NDEB to provide all information requested by the CDSA

NDEB ID Number: _____

Do you have a confirmed date for the NDECC Exam ○ Yes ○ No

If yes, please provide date: _____

Have you passed the Assessment of Fundamental Knowledge (AFK)? ○ Yes ○ No

Did you pass the AFK on the first attempt? ○ Yes ○ No

Have you passed the Assessment of Clinical Judgment (ACJ) in the last three years? ○ Yes ○ No

Did you pass the ACJ on the first attempt? ○ Yes ○ No

Placement Information

I understand that priority will be given to facilities located in underserved areas throughout Alberta to address community needs.

○ Yes ○ No

I am willing to re-locate for up to one (1) year.

○ Yes ○ No

Orientation Session

☐ I understand that I must attend the mandatory in-person Orientation Session on October 3 & 4, 2025 in Edmonton, Alberta

English Language Proficiency

An applicant may satisfy the English Language proficiency as specified in the CDSA English Language Proficiency Policy RP-01 or Canadian Language Benchmark (CLB) 11 or 12 requirement if they have one of the following.

- Official dental school or postgraduate transcripts related to dentistry were completed in English (transcripts must be received by the CDSA directly from the issuing organization)
- Letter or certificate of standing from a jurisdiction, which includes a description of the English language requirement for registration and the necessary scores on the required English language test, must be noted.(documentation must be received by the CDSA directly from the issuing jurisdiction)
- Official English language test results including the necessary scores. If yes, indicate which provider below
- Applicants currently in an active registration with another Alberta Oral Health Regulator (Hygienist, Dental Assistant, Denturist, Technologist) are considered to have met the requirements for English Language Proficiency.

☐ The International English Language Testing System (IELTS) Academic https://ielts.org/
☐ The Occupational English Test (OET) Dental test https://oet.com/
☐ The Canadian English Language Proficiency Index Program (CELPIP) General test https://www.celpip.ca/

Basic Life Support (HCP/CPR with AED)

Must have been completed within the last 12 months.

☐ Proof of current Basic Life Support (HCP/CPR including AED) is attached

Ethics & Jurisprudence Exam

☐ I understand if I am successful, I am required to complete the virtual Ethics and Jurisprudence Exam as part of my application

Required Fees

Supportive Pathway Application Fee: $500

Dentists accepted to the Supportive Pathway are on the Main Register, and upon registration the Fees required are:

- First Time Registration: $1,000
- Practice Permit Fee (term: October 1, 2025 – December 31, 2025): $2,453
- Annual Practice Permit Renewals are required by December 31of each year. Permit fees for the 2026 calendar year will be required and follow the CDSA Permit Fee Structure

Professional Liability Insurance

This insurance is included in the issuance of the CDSA practice permit.
The College of Dental Surgeons of Alberta program provides for professional liability coverage from insurers of $2,000,000 for any one claim and not less than $4,000,000 in aggregate.

General Dentistry Educational Information

(if additional spaces are required, please duplicate this page)

List all dental education credentials that you hold. Proof of completion will be required to be provided to the CDSA for each credential listed. A notarized copy of your degree(s)/certificates(s) is required.
Include other Dental professions, if applicable (i.e. Hygiene, Assisting, etc.).
Undergraduate information is not required.

Post Secondary 1

a. Institution: _____
b. Location: _____
c. Date Entered: _____ Date Left: _____
d. Degree/Certificate Earned: _____

☐ A notarized copy of Degree is attached
☐ Official transcripts from the post-secondary institution related to dental education have been requested to be supplied to the CDSA

Post Secondary 2 (if applicable)

a. Institution: _____
b. Location: _____
c. Date Entered: _____ Date Left: _____
d. Degree/Certificate Earned: _____

☐ A notarized or certified copy of Degree is attached
☐ Official transcripts from each post-secondary institution related to dental education have been requested to be supplied to the CDSA

Post Secondary 3 (if applicable)

a. Institution: _____
b. Location: _____
c. Date Entered: _____ Date Left: _____
d. Degree/Certificate Earned: _____

☐ A notarized or certified copy of Degree is attached
☐ Official transcripts from each post-secondary institution related to dental education have been requested to be supplied to the CDSA

Practice Information

Other Jurisdictions

Do you hold active dental healthcare registration in any of the following jurisdiction(s):
(Dentist, Hygiene, Assistant, etc.).

- ☐ Canada
- ☐ United States of America
- ☐ Internationally
- ☐ Not applicable

If yes, indicate jurisdiction(s) below.

Jurisdiction (Province/State/Country)	Registered/Licensed/Certified From:	To:

- ☐ A Consent for Release of Information form is attached for each jurisdiction noted above
- ☐ A Letter of Good Standing has been requested from all American and International jurisdictions I am currently active within as noted above

Were you previously registered/licensed as a dental healthcare provider in any of the following jurisdictions?
(Dentist, Hygiene, Assistant, etc.).

- ☐ Canada
- ☐ United States of America
- ☐ Internationally
- ☐ Not applicable

If yes, indicate jurisdiction(s) below.

Jurisdiction (Province/State/Country)	Registered/Licensed/Certified From:	To:

- ☐ A Certificate of Standing has been requested from all Canadian jurisdictions as noted above

☐ A Letter of Good Standing has been requested from all American and International jurisdictions, as noted above

☐ I acknowledge that a Consent for Release of Information form will be supplied for each jurisdiction in which I am actively registered within, as noted above

In-activity from Dentistry

Has there been a period during which you did not engage in the practice of dentistry on a continuous and regular basis? ◯ Yes ◯ No

If yes, indicate below.

Years(s)	Details	Location

In up to 500 words, please describe your relevant clinical and academic experience. This may include any initiatives you have undertaken to enhance your professional expertise in dental practice.

Conduct Information

- ☐ A Criminal Record Check and Vulnerable Sector Check from within the last 12 months is attached
- ☐ Consent for the release of information for the Criminal Record and Vulnerable Sector Check is attached

All the following questions **must** be answered. A **written explanation** must be provided for all affirmative answers. The information provided is kept confidential to the CDSA. If you are unclear or unsure about how to respond to any of these questions, please contact staff for clarification.

1.	Have you ever been found guilty of a criminal offence, either in Canada or in any other jurisdiction? This includes a finding of guilt under the Criminal Code of Canada, the *Controlled Drugs and Substances Act* (Canada) [(formerly the *Narcotic Control Act (Canada)*] and the *Food and Drugs Act* (Canada) or any other offences where the penalty could have involved you being incarcerated?	**Yes** ○	**No** ○
2.	Have you ever had any allegations of misconduct, including academic misconduct made against you, or have you ever been suspended, required to withdraw, expelled, or penalized for misconduct from any or all components of any academic program? If yes, provide details of the allegations, suspensions, expulsion, or penalty imposed upon you.	**Yes** ○	**No** ○
3.	Has there ever been a judgment in a civil action against you in relation to your practice?	**Yes** ○	**No** ○
4.	Has your entitlement to practice dentistry ever been limited, restricted, or subject to conditions in any jurisdiction at any time?	**Yes** ○	**No** ○
5.	Have you ever been refused registration in any jurisdiction?	**Yes** ○	**No** ○
6.	Have you ever voluntarily surrendered your registration/license/certificate?	**Yes** ○	**No** ○
7.	Have you ever practiced as a dentist without being registered/licensed/certified?	**Yes** ○	**No** ○
8.	At the present time, are there any investigations, reviews, or proceedings taking place in any jurisdiction that could result in sanctions against you including conditions of your practice permit, or the suspension or cancellation of your authorization to practice dentistry?	**Yes** ○	**No** ○
9.	Do you have a mental or physical condition that could affect your ability to safely practice dentistry? Examples: mental or physical ailment, psychiatric disorder, addiction, blood borne pathogens	**Yes** ○	**No** ○
10.	Do you have/have you held any other professional designation? If yes, provide a copy of the certificate. If yes, a Letter of Good Standing from all jurisdictions currently or previously registered is required.	**Yes** ○	**No** ○

Privacy and Security

The CDSA collects the above information for the purposes of registration within the province of Alberta. The information is only used or shared as regulated by the *Health Professions Act (HPA)* and *Privacy Information Protection Act (PIPA)*. The CDSA retains this information indefinitely in secured files.

Some of the information CDSA collects must be publicly accessible pursuant to the HPA.

Declaration

☐ I understand that submission of my application to the Supportive Pathway to NDEB Certification in Alberta does not guarantee acceptance into the program.

☐ I understand that if I am selected for the next stage of application, I will be contacted to arrange for an interview (either virtually or in-person).

☐ I understand that the fee for the evaluation of my application is $500.00. This fee is non-refundable but qualifies for two (2) years. A credit card payment authorization form for this amount is included.

I solemnly declare that the contents of this application for the Supportive Pathway Program 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 to my application, I shall be deemed not to have satisfied the requirements. I further understand and agree that if a Restricted Practice Permit should be issued to me based upon a false or misleading statement or representation, that Permit is subject to immediate cancellation.

_____

Signature of Applicant

Dated this _____ day of _____, 20____.

This form can be either printed and signed or digitally verified signature or DocuSign. Completed forms and supporting documents are to be sent to supportivepathway@cdsab.ca

Consent to Share Information from NDEB to the CDSA

Please complete this form and return it to:
College of Dental Surgeons of Alberta
Attention: Supportive Pathway
Suite 402, 7609 – 109 Street
Edmonton, Alberta T6G 1C3

I, _____
(FIRST NAME / LAST NAME)

hereby provide my consent:

1. To share my application information with NDEB for verification purposes.
2. To grant permission to the NDEB to provide all information requested by the CDSA.

Consent Statement:

☐ I consent to the above

NDEB ID Number: _____

I have duly executed this consent form this _____ day of _____,

20____.

_____
Printed Name of Applicant

_____
Signature of Applicant

Consent for Release of Information

College of Dental Surgeons of Alberta

Please complete this form and return it to:
College of Dental Surgeons of Alberta
Attention: Supportive Pathway
Suite 402, 7609 – 109 Street
Edmonton, Alberta T6G 1C3

I, _____
(FIRST NAME / LAST NAME)

have made application with the College of Dental Surgeons of Alberta for a Certificate of
(RECEIVING JURISDICTION)
Registration/License in order to engage in the practice of dentistry in Alberta.

The College of Dental Surgeons of Alberta, as part of its registration/licensure process, requires that it's Certificate of Standing form be completed by every jurisdiction in which I was licensed/registered and/or engaged as a health care professional (i.e.: hygienist/dental assistant) or applied for registration. As most jurisdictions require my consent to release the requested information, I am hereby signing my permission to and irrevocably authorize and direct the

_____
(ORIGINATING JURISDICTION)

to provide, at my expense, any information requested by the College of Dental Surgeons of Alberta. I understand and accept that this means providing full disclosure of any and all information that was obtained while performing this adjudicative function. This can include but is not limited to, amongst other matters, information whether deemed public or non-public, undertakings or agreements, verbal or written between me and the

_____
(ORIGINATING JURISDICTION)

about complaints, investigations, inspections, professional conduct, competence, fitness and capacity, past and present, and any and all applications as a health care professional including providing a copy of any written information in my

_____
(ORIGINATING JURISDICTION)

file pertaining to these matters and this shall be your full final and irrevocable authority for so doing.

Moreover, the College of Dental Surgeons of Alberta may wish further information or clarification respecting information it receives from the

_____
(ORIGINATING JURISDICTION)

in connection with my application and I hereby further authorize the

_____
(ORIGINATING JURISDICTION)

to assist and co-operate with the College of Dental Surgeons of Alberta in providing any other/ additional information it might request or that the

_____
(ORIGINATING JURISDICTION)

deems to be relevant to my application in Alberta.

It is understood and acknowledged by me that I have been advised by the College of Dental Surgeons of Alberta that I might wish to obtain legal advice prior to executing this consent and that I have either done so or have had sufficient opportunity to do so prior to executing this consent for release of information. I am signing this document of my own free will, voluntarily and without coercion, having read it and having understood it.

I have duly executed this release form this _____ day of _____, 20____.

_____
Printed Name of Applicant

_____
Signature of Applicant

College of Dental Surgeons of Alberta

Supportive Pathway to NDEB Certification in Alberta
Consent to Request and Release of
Vulnerable Sector and Criminal Record Search
(To be provided to the CDSA)

Legal Name: First 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.

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 accepted to the program.

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 for acceptance to the program. 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

College of Dental Surgeons of Alberta

SUPPORTIVE PATHWAY TO NDEB CERTIFICATION
STATUTORY DECLARATION

In the matter of my application for approval towards Registration with the *College of Dental Surgeons of Alberta* under Part 2 of the *Health Professions Act*.

I, _____ of _____
(Print Full Name) (City)

("the Declarant") in the Province of_____, **DO SOLEMNLY DECLARE:**
(Province)

1) that I was born on _____ , at;_____
(Place)

2) that I am the person referred to in the documents submitted in support of my application, and that these documents present a true and accurate account of my qualifications;

AND I make this solemn declaration conscientiously believing it to be 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*.

DECLARED BEFORE ME at the City of)
_____,)
in the Province of _____,)
this _____ day of _____,)
20_____.)

_____)
Declarant

_____
A Notary and/or Commissioner for Oaths

_____
Print Name and Expiry Date (or stamp)

Photograph

Passport size, of applicant, taken no more than six months before the date of application, must be pasted in this space.

CDSA
College of Dental Surgeons of Alberta

Application Fee
Supportive Pathway to NDEB Certification

One Time Credit Card Payment Authorization Form

Please complete and sign this form to authorize the College of Dental Surgeons of Alberta to make a one-time charge to the credit card listed below.

AUTHORIZATION

I, _____ authorize the College of Dental Surgeons of Alberta to charge the credit card account indicated below for the amount of $500.00 on or after _____ for the purpose of the Application fee.
Date

APPLICANT CONTACT INFORMATION

Address _____ Phone Number _____

_____

City and Province _____ Postal Code _____

Email _____

Card Type: ☐VISA ☐Debit VISA ☐MasterCard ☐American Express

Cardholder Name (as appears on front of card): _____

Card Number: _____

Expiration Date: _____ CVV Number: _____

SIGNATURE _____ **DATE** _____

The College of Dental Surgeons is hereby authorized to charge the credit card indicated in this authorization form according to the terms outlined above. This payment authorization is for the application fee indicated above, and is valid for one time use only. I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit card company, so long as the transaction corresponds to the terms indicated in this form.

Accounting records are kept in order to invoice and process the appropriate fees for applications. Information collected is used for the purpose noted above and then destroyed by confidential shredding.