

Self-Reporting to the College

Use this form to self-report to the College if:

- your ability to provide safe, competent care has been compromised
- another professional regulatory body has found you guilty of unprofessional conduct
- you have been the subject of a formal or informal alternative complaint process with another professional regulatory body to resolve a complaint of unprofessional conduct against you
- any findings of professional negligence (and / or malpractice) have been made against you
- you have been charged with an offense under the Criminal Code
- you have pleaded guilty, been found guilty or received a conditional discharge of (i) an offence under the Criminal Code for which you have not been pardoned or (ii) an offence of a similar nature in a jurisdiction outside of Canada for which you have not been pardoned
- there is anything else that may have a material negative impact on your fitness to practice dental assisting

You must¹ promptly report all of the above to the College. The Registrar will review your self-report and notify you in writing of the results.

How to complete this form

Step 1: Review the [Privacy information](#) on our website to understand how we use your personal information.

Step 2: On this form, fill in the Registrant Information section.

Step 3: Fill in the Disclosure section(s) that apply to you. Attach page(s) if you need more space.

Step 4: Sign and date the form at the bottom of the last page.

Step 5: Attach documents if required.

Step 6: Mail, email courier or hand-deliver your completed form to our Registrar at:

College of Alberta Dental Assistants
Attention: Registrar
166-14315 118 Ave NW
Edmonton AB T5L 4S6
registrar@abrda.ca

¹ As required by the *Health Professions Act, Dental Assistants Profession Regulation, Standards of Practice and Code of Ethics*

Registrant Information

Name _____ Registration number _____

Email _____ Phone _____

Fitness to Practice Disclosure

Select the nature of your disclosure (a specific medical or other diagnosis is not required):

- Cognitive Impairment** (disorder that affects attention, judgement and problem solving, planning and sequencing, memory, insight, reaction time, and results in substantial limitation of ability to perform activities)
- Sudden Incapacitation** (disorder that has a moderate to high risk of sudden incapacitation, or that has resulted in sudden incapacitation and that has a moderate to high risk of reoccurrence)
- Motor or Sensory Impairment** (disorder resulting in severe motor impairment that affects coordination, muscle strength and control, flexibility, motor planning, touch or positional sense)
- Visual Impairment** (disorder that restricts vision that hasn't been or can't be corrected)
- Substance Use/Abuse Disorder** (a substance use/abuse disorder and/or non-compliance with treatment recommendations)
- Psychiatric Illness** (disorder involving acute psychosis, severe abnormalities of perception, or suicidal plan)
- Other** (provide a description of the disorder that may impact your ability to provide safe and competent oral health care as a dental assistant)

Date of diagnosis (if applicable) _____

This disorder is permanent temporary

If temporary, what is the prognosis for recovery? _____

Describe the limitation(s) and restriction(s) arising from the disorder _____

Are you following a recommended treatment program? Yes No

Are you taking any medications which may impact your ability to provide safe and competent oral health care?

Yes (explain, including providing a list of medications) _____

No

Unprofessional Conduct/Alternative Complaint Process Disclosure

Attach a copy of the decision, alternative complaint resolution agreement or other documents if available, and provide this information about the professional regulatory body:

Name of regulatory body _____

Address _____

Phone _____ Email _____

Contact person _____

Date of proceedings _____

Outcome (if known) _____

Professional Negligence and/or Malpractice Disclosure

Attach a copy of the decision, if available.

Nature of finding(s) _____

Description of finding(s) _____

Date of finding(s) _____

Criminal Offence Disclosure

Attach a copy of the decision, if available.

Nature and circumstances of offence _____

Date of charges or pleading/finding of guilt _____

Description of sentence/sanctions _____

Have you complied with all sanctions?

Yes No (explain) _____

Statement addressing whether the charge/findings impact your ability to provide safe and competent oral health care as a dental assistant:

Any other information that you would like to provide including recent behaviour and or remedial activities you have undertaken:

Registrant Signature

Date