

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.

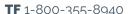
How to complete this form

- **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

April 3, 2020 1



 $^{^1 \,} As \ required \ by \ the \ \textit{Health Professions Act}, \ \textit{Dental Assistants Profession Regulation}, \ Standards \ of \ Practice \ and \ Code \ of \ Ethics$

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 \square permanent \square 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? \square Yes \square 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) _____ \square No

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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 a	nd/or Malpractice Disclosure	
Attach a copy of the decision, if available.		
Nature of finding(s)		
Description of finding(s)		
Date of finding(s)		

TF 1-800-355-8940

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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 is care as a dental assistant:	impact your ability to provide safe and competent oral health
Any other information that you would like to provide have undertaken:	le including recent behaviour and or remedial activities you
Designature	Data
Registrant Signature	Date
Apr. 7, 20	