

Verification of Standing

If you are or have been registered, licensed or certified anywhere (province/state/country) as a dental assistant (other than with our College) or any other regulated profession you must use this form.

1. Make enough copies of this form for each organization you are/have been a member of.
2. Use one copy for each organization.
3. You complete Part A only.
4. Leave Part B blank.
5. Send Part A and Part B to the organization you name below.
6. Verification of Standing forms are valid for 30 days after the date they are completed by the regulatory authority. Plan accordingly.

Part A: Consent for Release

I have made application with the College of Alberta Dental Assistants for registration in order to engage in the practice of dental assisting in the province of Alberta. I, therefore, hereby irrevocably authorize and request that:

Name of organization you are/have been a member of

(hereinafter referred to as “receiving regulatory authority”)

provides to the College of Alberta Dental Assistants full disclosure of any and all information the receiving regulatory authority may have respecting my professional conduct, competence and capacity including providing a copy of any written information in my file pertaining to these matters and this shall serve as the receiving regulatory authority’s full, final and irrevocable authority for so doing.

I understand the legal implications and approve the receiving regulatory authority’s release of any information requested by the College of Alberta Dental Assistants.

I understand that I have the right to seek legal advice prior to signing this form.

Signature of Applicant

Print Applicant’s Name

Applicant’s Registration, License
or Certificate Number with
Receiving Regulatory Authority

Date

Part B: Registration/License/Certification Information

To be completed by the regulatory authority and forwarded directly to the College of Alberta Dental Assistants at:

application@abrda.ca

780-486-2728 (fax)

166-14315 118 AVE NW

Edmonton Alberta T5L 4S6

APPLICANT'S REGISTRATION/LICENSE/CERTIFICATION (R/L/C) INFORMATION

Name _____ R/L/C Number _____

Profession Dental Assistant Other (provide professional title) _____

The applicant has held R/L/C in

_____ From _____ To _____
Receiving regulatory authority's jurisdiction MM/DD/YYYY MM/DD/YYYY

Current Status

Practicing/active Non-practicing/inactive Other (specify and provide an explanation) _____
 Suspended/cancelled Provisional/temporary/conditional _____

Has the applicant ever had terms, restrictions, conditions or limitations on her or his R/L/C?

Yes – attach a description and the dates in force No

Has the applicant ever had her or his R/L/C suspended, cancelled, revoked or struck from a Register of your organization?

Yes – attach a description and the dates in force No

Has the applicant ever been the subject of a formal complaint, investigation or disciplinary proceeding in the nature of professional misconduct, incompetency or incapacity, or a like finding made against her or him?

Yes – attach a description and the dates in force No

Has the applicant always been in compliance with your competence/professional development/quality assurance program requirements?

Yes No – attach a description and the dates in force

REGULATORY AUTHORITY'S INFORMATION

Organization Name and Address

Corporate Seal

Telephone _____

Email _____

I certify that the information provided on and attached to this form are true statements of the R/L/C record for the applicant.

Signature _____ Print Signatory's Name _____

Date _____ Signatory's Title _____

Feb. 27, 20

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