College of Alberta Dental Assistants

Application for Authorization to Perform Nasopharyngeal Swabbing

Use this two-part application to:

A) apply for authorization to participate in supervised education and training (Part A)
B) apply for authorization to perform nasopharyngeal swabbing for the purposes of testing for COVID-19, as per Ministerial Order 645/2020 (Part B)

You may apply if you:

- are listed on the General Register and hold a valid Practice Permit; and,
- plan to participate in education and training for nasopharyngeal specimen collection, as approved by Alberta Health Services, so that you may be authorized to perform nasopharyngeal swabbing for COVID-19 testing.

Requirements

PART A: AUTHORIZATION FOR SUPERVISED EDUCATION AND TRAINING

You must meet these requirements to qualify for authorization to perform supervised nasopharyngeal swabbing for clinical training purposes:

1. review the video series for nasopharyngeal specimen collection practises (https://www.albertahealthservices.ca/lab/Page14607.aspx)
2. obtain the consent of an Alberta regulated health care practitioner (who is authorized by their respective regulatory body to perform nasopharyngeal swabbing) to supervise you while you perform nasopharyngeal swabbing as part of your competence development and training* activities
3. submit *Part A: Notification and Supervision Consent Form Nasopharyngeal Swabbing*
4. pay Advanced Practice Assessment Fee invoice in the CADA Portal when we notify you

PART B: AUTHORIZATION FOR UNSUPERVISED PRACTICE

You must meet these requirements to qualify for authorization to perform unsupervised nasopharyngeal swabbing:

1. complete supervised clinical training* for nasopharyngeal swabbing
2. submit *Part B: Completion of Nasopharyngeal Swabbing Training Form*
3. submit verification of successful completion of nasopharyngeal swabbing training*

*To meet the requirements of the Ministerial Order, training must be approved by Alberta Health Services.

166-14315 118 Ave NW, Edmonton, AB T5L 4S6 **P** 780-486-2526 **TF** 1-800-355-8940 **W** abrda.ca

Part A: Notification and Supervision Consent Form Nasopharyngeal Swabbing

Use this form to apply for authorization to engage in supervised nasopharyngeal swabbing for clinical competency development training.

Personal Information

Name _____ Registration # _____

Mailing Address _____

City/Province/Country _____ Postal Code _____

Phone _____ Email _____

Employment Information

Employer Name _____

Employer Mailing Address _____

City/Province _____ Postal Code _____

Employer Phone _____ Employer E-mail _____

Employment Start Date _____ (MM/DD/YYYY) Average hours per week ❑ 0-15 ❑ 16-32 ❑ 33+

Job Description _____

Application Assessment Fee

When we receive your *Part A: Notification and Supervision Consent Form Nasopharyngeal Swabbing*, we will issue you an invoice for the $26.25 assessment fee.

- We will notify you by email that we have received your *Part A: Notification and Supervision Consent Form Nasopharyngeal Swabbing* and issued your invoice for the $25.25 Advanced Practice Assessment Fee.
- You will be able to access and pay your invoice in the CADA Portal.
- You must pay the invoice to complete this part of the application process. We will not assess your application until you pay the fee.

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Applicant's Notification to the College

❑ I am notifying the College of Alberta Dental Assistants that I will be developing the competence to perform the restricted activity of "To insert or remove instruments, devices, fingers, or hands beyond the point in the nasal passages where they normally narrow for the purposes of nasopharyngeal swabbing."

Anticipated training dates:

Start _____ Completion _____
(MM/DD/YYYY) (MM/DD/YYYY)

❑ I have reviewed the video series for nasopharyngeal specimen collection practises found at the following Alberta Health Services link: https://www.albertahealthservices.ca/lab/Page14607.aspx.

Supervisor's Statement

The following Supervisor Consent section must be completed by the Alberta regulated health care practitioner who agrees to supervise the applicant while the applicant performs nasopharyngeal swabbing for clinical competency development training.

SUPERVISOR CONSENT

Supervisor Name _____

Supervisor Phone _____ Supervisor E-mail _____

I Declare, Acknowledge and Understand that:

❑ I am a regulated member of (*insert College name*) _____ and I am authorized to perform nasopharyngeal swabbing. My registration number is _____.

❑ By signing this Form, I provide my consent to supervise the applicant (*insert Registered Dental Assistant's name*) _____while they perform nasopharyngeal swabbing as part of their competence development and training activities, and understand that I must be on-site and available to consult or assist with this restricted activity when it is being performed.

Signed _____ _____
Supervisor's Signature Date (MM/DD/YYYY)

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Applicant's Statement

For each statement that you check "I Disagree" you must include a written explanation with this application.

MY CONSENT, TRUE AND CORRECT APPLICATION

The information you give us is protected. Refer to our website for more information about privacy and disclosure.

I Acknowledge and Understand that:

- ❑ By submitting this application to the College, I provide my consent to the College to collect, use and disclose my personal information as required for reasonable matters including fulfillment of statutory requirements.
- ❑ I certify that the information given and made part of this application is true and correct in every aspect.

MY RESPONSIBILITIES

I Agree	*I Disagree*	
❑	❑	I will pay the $26.25 Advanced Practice Assessment Fee invoice in the CADA portal when notified to do so by the College.
❑	❑	I will complete all requirements for unsupervised nasopharyngeal swabbing authorization and I will only practice unsupervised nasopharyngeal swabbing after I have received written confirmation from the College that I am authorized to do so.
❑	❑	After I receive written confirmation from the College that I am authorized to perform supervised nasopharyngeal swabbing, I will only perform nasopharyngeal swabbing under the direction and supervision of the supervisor who has provided consent as part of this application, and only for the purposes of my competence development and training, until such time as I receive written confirmation from the College that I am authorized to perform unsupervised nasopharyngeal swabbing.
❑	❑	After I successfully complete nasopharyngeal swabbing competence development and training, I will submit *Part B: Completion of Nasopharyngeal Swabbing Training Form* to the College, and I will only perform unsupervised nasopharyngeal swabbing after I receive written confirmation from the College that I am authorized to do so.
❑	❑	I fully understand my responsibilities and that failure to comply with any or all of the above may result in cancellation or suspension of my Practice Permit, and subsequent notification of my cancellation or suspension pursuant to statutory requirements.

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Terms and Conditions

Before submitting your application, please carefully review the following Terms and Conditions:

- When we receive your *Part A: Notification and Supervision Consent Form Nasopharyngeal Swabbing* we will issue you an invoice for the $26.25 Advanced Practice Assessment Fee. You must pay the fee in the CADA Portal to make your application Part A complete. The fee is **non-refundable**.
- Each application for nasopharyngeal swabbing authorization will be reviewed on an individual basis.
- We will notify you by email of the result of our review.
- If you meet the eligibility requirements, we will add a practice condition to your practice permit.
- The Registrar may request that you submit additional information in order to verify your eligibility.
- If your application is incomplete and/or if the Registrar requests additional information, we will hold your application for up to 45 days. You must complete all incomplete/missing requirements and/or submit additional information within 45 days. If you do not complete all of the requirements within that 45-day period, your application will expire and you will forfeit the $26.25 Advanced Practice Assessment Fee. Your expired application and supporting documents will not be returned to you. If your application expires, you must begin a new application to apply for nasopharyngeal swabbing authorization. If you begin a new application in the future, you must pay the Advanced Practice Assessment Fee again.
- Fees are subject to change at any time.
- Our policies are subject to change without notice.

GENERAL TIMELINE FOR REVIEW OF APPLICATIONS

- We will notify you of the result of our assessment within 5 business days of receiving your *Part A: Notification and Supervision Consent Form Nasopharyngeal Swabbing* and fee.
- If your application Part A is incomplete or we require additional information, the process may take longer.

I accept the Terms and Conditions above.

Signed _____ _____

Applicant's Signature | Date (MM/DD/YYYY)

Submit Your Application

Submit your *Part A: Notification and Supervision Consent Form Nasopharyngeal Swabbing* to us by email application@abrda.ca or fax 780-486-2728

Questions? Need help?

Email ***application@abrda.ca*** or call 780-486-2526

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Part B: Completion of Nasopharyngeal Swabbing Training Form

After you have completed education and clinical competency development for nasopharyngeal swabbing, use this form to apply for authorization to perform unsupervised nasopharyngeal swabbing.

Personal Information

Name _____ Registration # _____

Mailing Address _____

City/Province/Country _____ Postal Code _____

Phone _____ Email _____

Clinical Training

Include a copy of your verification of training.

❑ I have successfully completed clinical training for nasopharyngeal swabbing that has been approved by Alberta Health Services.

Supervisor's Statement

The following Supervisor Consent section must be completed by the Alberta regulated health care practitioner who provided supervision to the applicant while the applicant performed nasopharyngeal swabbing for clinical competency development training.

SUPERVISOR CONSENT

Supervisor Name _____

Supervisor Phone _____ Supervisor E-mail _____

I Declare, Acknowledge and Understand that:

❑ I am a regulated member of (*insert College name*) _____ and I am authorized to perform nasopharyngeal swabbing. My registration number is _____.

❑ By signing this Form, I confirm I have supervised the applicant (*insert Registered Dental Assistant's name*) _____ when they performed nasopharyngeal swabbing as part of their competence development and training activities. I declare that this Registered Dental Assistant has met the competency development and training requirements to be authorized to perform nasopharyngeal swabbing independently.

Signed _____ _____

Supervisor's Signature Date (MM/DD/YYYY)

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Applicant's Statement

For each statement that you check "I Disagree" you must include a written explanation with this application.

MY CONSENT, TRUE AND CORRECT APPLICATION

The information you give us is protected. Refer to our website for more information about privacy and disclosure.

I Acknowledge and Understand that:

- ❑ By submitting this application to the College, I provide my consent to the College to collect, use and disclose my personal information as required for reasonable matters including fulfillment of statutory requirements.
- ❑ I certify that the information given and made part of this application is true and correct in every aspect.

MY RESPONSIBILITIES

I Agree	*I Disagree*	
❑	❑	I have completed all requirements for supervised nasopharyngeal swabbing authorization.
❑	❑	I will only perform nasopharyngeal swabbing after I receive written confirmation from the College that I am authorized to do so.
❑	❑	I will only perform nasopharyngeal swabbing when I am competent after proper education, training, and experience.
❑	❑	I will only perform nasopharyngeal swabbing for the purposes of COVID-19 testing, as per Ministerial Order 645/2020.
❑	❑	I fully understand my responsibilities and that failure to comply with any or all of the above may result in cancellation or suspension of my Practice Permit, and subsequent notification of my cancellation or suspension pursuant to statutory requirements.

GENERAL TIMELINE FOR REVIEW OF APPLICATIONS

- We will notify you of the result of our assessment within 5 business days of receiving your *Part B: Completion of Nasopharyngeal Swabbing Training Form*.
- If your application Part B is incomplete or we require additional information, the process may take longer.

Signed _____ _____

Applicant's Signature — Date (MM/DD/YYYY)

Submit Your Application

Submit your *Part B: Completion of Nasopharyngeal Swabbing Training Form* to us by email application@abrda.ca or fax 780-486-2728

Questions? Need help?

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