

# Application for Student Membership

Use this form to apply for student membership if you are enrolled in an Alberta dental assisting program approved by the College, or if you are enrolled in a recognized\* Canadian distance delivery program and are residing and/or employed in Alberta.

*\*Graduates must be eligible to sit the National Dental Assisting Examining Board (NDAEB) theory exam*

## Requirements

**You must meet these requirements to qualify for student membership:**

1. Demonstrate proof of identity.
2. Demonstrate enrollment in a dental assisting program described above.
3. Submit this application form and all supporting documents.

## Personal information

**Include a copy of Canadian government issued identification that has your legal name and date of birth. (e.g. driver's license, passport, resident card, citizenship card)**

**If your legal name is different than the name on any of your verification documents, include a copy of legal documents that verify your name change. (e.g. marriage certificate, legal name change document)**

**In the First and Last Name areas, provide your legal name as it appears on your identification. If you go by a different first name, provide it as your Common/preferred name. If your name has changed since birth, provide all names you have previously used as your Former Name(s).**

*Enter the requested information below.*

First name \_\_\_\_\_ Date of birth \_\_\_\_\_  
(MM/DD/YYYY)

Last name \_\_\_\_\_

Common/preferred name \_\_\_\_\_

Former name(s) \_\_\_\_\_

My name has not changed since birth

Gender (optional):     Female     Male     Other/prefer not to say

## Contact information

**You must provide a phone number, a mailing address where you can receive correspondence, and a personal email address. We will contact you by email about the status of your application.**

*Enter the requested information below.*

Mailing address \_\_\_\_\_

City/province/country \_\_\_\_\_ Postal code \_\_\_\_\_

Home phone \_\_\_\_\_ Mobile phone \_\_\_\_\_

Email \_\_\_\_\_

## Languages

Which language(s) can you use to provide dental assisting services?

Languages \_\_\_\_\_

## Program enrollment requirement

**Enter the requested information and include a copy of your verification of program enrollment document. Make sure your verification document shows your name, the name of the school, the name of the program, start date of program and end date of program.**

Institution/school name \_\_\_\_\_

Program name \_\_\_\_\_

Program start date \_\_\_\_\_ Program end date \_\_\_\_\_

Location of school \_\_\_\_\_ Type of program  day program  distance delivery

## Current employment information

*Check off your current employment status.*

I am currently unemployed. Unemployed since: \_\_\_\_\_  
Provide date (MM/DD/YYYY)

I am currently employed in a non-dental field. Employed non-dental since: \_\_\_\_\_  
Provide date (MM/DD/YYYY)

I will be starting work or am currently employed in the dental field. (provide information below, list all employers, if you need more space provide information on a separate sheet)

Employer name \_\_\_\_\_ Employer city \_\_\_\_\_

Employment start date \_\_\_\_\_ Average hours per week  0-15  16-32  33+  
(MM/DD/YYYY)

Job description \_\_\_\_\_

Employer phone \_\_\_\_\_ Employer email \_\_\_\_\_

May 11, 26

# Applicant's statement

## My consent, true and correct application

The information you give is protected. Refer to the privacy information available on our [website](https://abrda.ca/) (<https://abrda.ca/>) for more information about privacy and disclosure.

*I acknowledge and understand that:*

- I understand that Student Membership with the College does not authorize me to perform any dental assisting services.
- 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.
- The College uses service providers to carry out its regulatory functions. By submitting this application to the College, I provide my consent for the disclosure of my personal information by the College to its service providers, including for the purposes of service providers contacting me regarding carrying out the College's professional regulatory functions. This includes my consent for the purposes of the *Personal Information Protection Act* and the *Personal Information Protection and Electronic Documents Act*.
- I certify that the information given and made part of this application is true and correct in every aspect.

## Terms and conditions

**Before submitting your application please carefully review the following terms and conditions:**

- We will assess your application within 10 business days and notify you by email of the result.
- If your application is incomplete and/or you do not meet the eligibility requirements, we will hold your application for up to 45 calendar days. You must complete all incomplete/missing requirements and submit verification within 45 calendar days. If you do not complete all the requirements, within that 45-day period your application will expire.
- Our policies are subject to change without notice.

*I accept the terms and conditions above.*

Signed \_\_\_\_\_

Applicant's signature

\_\_\_\_\_ Date (MM/DD/YYYY)

## Submit your application

Submit your application to: [application@abrda.ca](mailto:application@abrda.ca) OR College of Alberta Dental Assistants  
166-14315 118 Ave NW  
Edmonton AB T5L 4S6

We will send you an email to confirm that we received and processed your request within 10 business days.

### Questions? Need help?

Email [application@abrda.ca](mailto:application@abrda.ca) or call 780-486-2526