

**APPLICATION FOR REGISTRATION IN NEW ZEALAND FOR HOLDERS OF  
NEW ZEALAND QUALIFICATIONS**

**THIS FORM IS VALID UNTIL 30 SEPTEMBER 2011**

**Attach** 1 certified  
passport photo here.

- This application is to be used by holders of prescribed New Zealand qualifications who are seeking eligibility to apply for registration in New Zealand. (This form is NOT for New Zealand Dental Registration Examination candidates)
- Please print all answers clearly.
- Please submit **all** supporting documents with your application. Incomplete applications will be returned.

<b>Name</b>	
Given names	Family name
Other names	Title
If your name differs from any previous Dental Council documentation or from those displayed on your dental qualification, and you haven't previously submitted the supporting documentation, please tick box to show reason, and <b>attach</b> evidence.	
<input type="checkbox"/> Marriage <input type="checkbox"/> Deed Poll <input type="checkbox"/> Common Use <input type="checkbox"/> Other (explain)	

<b>Scopes of Practice</b>												
Please select the scope of practice and any additional scopes of practice which you are seeking registration in.												
<input type="checkbox"/> <b>General Dental</b>												
<input type="checkbox"/> <b>Dental Specialist</b> <table border="0"> <tr> <td><input type="checkbox"/> Endodontics</td> <td><input type="checkbox"/> Oral and Maxillofacial Surgery</td> </tr> <tr> <td><input type="checkbox"/> Oral Medicine</td> <td><input type="checkbox"/> Oral Pathology</td> </tr> <tr> <td><input type="checkbox"/> Oral Surgery</td> <td><input type="checkbox"/> Orthodontic</td> </tr> <tr> <td><input type="checkbox"/> Paediatric Dentistry</td> <td><input type="checkbox"/> Periodontic</td> </tr> <tr> <td><input type="checkbox"/> Prosthodontic</td> <td><input type="checkbox"/> Public Health Dentistry</td> </tr> <tr> <td><input type="checkbox"/> Restorative</td> <td><input type="checkbox"/> Special Needs Dentistry</td> </tr> </table>	<input type="checkbox"/> Endodontics	<input type="checkbox"/> Oral and Maxillofacial Surgery	<input type="checkbox"/> Oral Medicine	<input type="checkbox"/> Oral Pathology	<input type="checkbox"/> Oral Surgery	<input type="checkbox"/> Orthodontic	<input type="checkbox"/> Paediatric Dentistry	<input type="checkbox"/> Periodontic	<input type="checkbox"/> Prosthodontic	<input type="checkbox"/> Public Health Dentistry	<input type="checkbox"/> Restorative	<input type="checkbox"/> Special Needs Dentistry
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**Identification**

Please **attach** certified copies of the identification pages of your passport to confirm your identity. If you are a New Zealand citizen, you may substitute a certified copy of your New Zealand driver's license in place of the identification pages of your passport. **Please note** that all documentation where identification verification is required should be **certified by the same person**, as authorised by the law of your country of residence to administer an oath for the purpose of a judicial proceeding; which include your passport photo, copies of your identification pages, verification of identity section of this form (p7) and the statutory declaration section of this form (p9).

Birthplace (including country)

Date of birth (day, month, year)

Gender (please tick)

 Male Female**Contact Details**

You are required by law to advise the Council of your postal, residential and if applicable, your practice address. All written communications will be sent to your postal address. Note that Section 140 of the Health Practitioner's Competence Assurance Act 2003 requires that all registered practitioners keep the Dental Council informed of their current postal, residential and, if relevant, practice addresses.

Postal address	Residential address (if different from your postal address)	New Zealand practice address (if known)
Phone	Phone	Phone
Mobile	Mobile	Mobile
Fax	Fax	Fax
Email	Email	Email

**Previous Registration Applications**

Have you previously applied for registration with the Dental Council?

 Yes No**First Dental Qualification**

Please provide details of your primary dental qualification upon which you are basing your registration application and **attach** a certified copy of your diploma or degree certificate.

Country of qualification	Issuing authority	Name of qualification	Year awarded	Duration of programme	Full or part time	Dates attended

**Post-graduate Qualifications**

Please provide details of your post-graduate qualifications upon which you are basing your registration application (if applicable) and **attach** a certified copy of your diploma or degree certificate.

Country of qualification	Issuing authority	Name of qualification	Year awarded	Duration of programme	Full or part time	Dates attended

**Licensing Examinations**

Please provide details of any relevant licensing or registration examinations you have sat. Please attach a certified copy of your national and/or state license if applicable.

Country	Examination	Exam Date	Result

**Current and Past Registrations**

Please provide details of your current and past dental registrations (including specialist registrations) in other countries and **attach**:

- a certified copy of your registration certificate(s)
- **original** Certificates of Good Standing (no older than three months) from relevant Boards/Council's where registration is, or has been held in the last seven years.

Country/state	Date registered	Registration status (including branch of dentistry registered in)

### Training/Continuing Professional Development Activities

In determining whether you are competent to practise in New Zealand, the Dental Council will consider amongst other things, the extent and recency of your practise and whether or not you have completed appropriate continuing professional development (CPD) over the last three years. Under sections 27 and 29 of the Act a practising certificate cannot be issued to a practitioner who had not held one in the past three years unless the Council is satisfied that the applicant meets the required standard of competence. In the sections below, please provide details of post-graduate dental training and CPD activities, which you have completed and are relevant to the scope(s) of practice you are applying for.

Name of course	Course provider	Date

### Practice Experience

Please **attach** a copy of your Curriculum Vitae with your application, ensuring that it provides full details of:

- your relevant work experience and current employment;
- the extent of your clinical experience in the range of tasks delineated in the general scope of practice in which you are seeking registration; and
- the CPD you have undertaken in the past three years.

Please provide details of your post-graduate dental work experience (full/part time).

Details	Location	Date

### Professional Referees

You must arrange for three **professional** references (with at least one referee being your current or most recent employer or clinical supervisor from the last location you worked at as an oral health professional and another from a clinical peer registered in the Scope of Practice that you want to apply for registration) to be forwarded **directly from the referee** to the Dental Council. The reference must be completed using the Dental Council standard referee report form which can be downloaded at: [http://www.dcnz.org.nz/Documents/Forms/R001\\_RefereeReport.pdf](http://www.dcnz.org.nz/Documents/Forms/R001_RefereeReport.pdf)

Please note the Dental Council will not accept references that have been completed by family members or personal acquaintances.

Name	Employer/Clinical Supervisor
Name	Clinical Peer
Name	Relationship to applicant

### Mental and Physical Condition

You are required to disclose any mental physical condition; impairment or addiction and provide full details.

#### Hepatitis B & C status

Please **attach** an original typed and signed Hepatitis B and C report, including Hepatitis B surface antigen and antibody and Hepatitis C antibody from a New Zealand laboratory; or a New Zealand registered International Accreditation New Zealand (IANZ) laboratory; or from an overseas laboratory which is party to a mutual recognition arrangement with the IANZ [www.ianz.govt.nz](http://www.ianz.govt.nz); or a laboratory registered to provide services for New Zealand Immigration. Please note that the Hepatitis report must be less than six months old at the time of receipt and you must ensure that the test request form includes in the "clinical details" section a request for your identity to be verified against your passport photograph and your passport number recorded on the form.

If you supply a report from an accredited overseas laboratory you must also provide a certified copy of the laboratory's certificate of accreditation, including a copy of the laboratory's scope of accreditation so that we can identify that the laboratory has accreditation to carry out the required Hepatitis test.

The test for Hepatitis will indicate whether:

- You have never been infected with the hepatitis B virus and never been successfully vaccinated against hepatitis B. In this case your blood will be hepatitis B surface antigen negative and hepatitis B surface antibody negative; or
- You have been infected with hepatitis B and have eliminated the infection, or been successfully vaccinated against hepatitis B. Your blood will be hepatitis B surface antigen negative and hepatitis B surface antibody positive; or
- You have been infected with hepatitis B and have failed to eliminate the infection. Your blood will be hepatitis B surface antigen positive.

If results show you have never been infected or vaccinated, you are strongly advised to be vaccinated.

If you are infected with hepatitis B we would strongly recommend that you have further specialised tests. If these tests show that you are infectious (HBeAG positive) or HBeAG negative with a high viral load demonstrated by HBV DNA you are unlikely to be eligible for registration in New Zealand. The Dental Council may however seek further advice on a case by case basis.

If the screening test for hepatitis C is positive you are strongly advised to have this followed up by hepatitis C PCR test. If this is positive you are unlikely to be eligible for registration in New Zealand. The Dental Council may however seek further advice on a case by case basis.

Have you ever been affected by a mental or physical condition with the potential to affect your fitness to practice? Please detail neurological, psychiatric or addictive (drugs or alcohol) disorders (including physical deterioration due to injury, disease or degeneration).

Yes  No

If yes, please **attach** full details on a separate sheet. Include: details of illness, duration of treatment, name and contact details of treating practitioner, involvement of teaching institution/employer.

I confirm I have **attached** my current hepatitis B & C report to this application? (Please note your application cannot progress without this document).

Yes  No

### Convictions

Have you ever been convicted of an offence punishable by imprisonment for a term of three months or longer by any Court in New Zealand or any other country?

Yes  No

If yes, please **attach** a certified copy of your conviction history.

### Conduct/Character

Are you now, or have you ever been, the subject of an investigation by an employer, a registration or professional body or educational institution in respect of any matter that was, or may be, the subject of professional disciplinary proceedings?

Yes  No

If yes, please **attach** full details on a separate sheet. Include (if applicable) conditions on your registration/employment.

### Professional Competence

Disclosure of information concerning your competence to practice is required to enable the Council to carry out its principal purpose of 'protecting the health and safety of members of the public' and to ensure you satisfy the statutory requirements for registration.

You must provide details of any competence inquiries, conditions on your employment or registration; and termination or suspension of registration or employment. Any correspondence with you concerning your responses to the sections on fitness or competence to practice will be sent to you in envelopes marked "Private and Confidential." You may wish to nominate an alternative address for correspondence on any fitness or competence issues.

Are you now, or have you ever been, the subject of competence enquiry by an employer, a registration or professional body or educational institution in respect of any matter that was, or may be, the subject of professional disciplinary proceedings?

Yes             No

Have you now, or have you ever had any conditions on your registration or employment?

Yes             No

Have you ever had your employment or registration terminated or suspended?

Yes             No

If you have answered yes to any of these questions, please **attach** full details on a separate sheet.

### Dental Register

The Dental Council collects personal information from you for the purpose of administering the provisions of the Health Practitioners Competence Assurance Act 2003. In collecting and handling your personal information the Dental Council will comply with this Act and the Privacy Act 1993.

Under the Act certain information including your name, registration number, scope of practice and qualifications must be included on the Dental Register and made publicly available. In addition the Act requires you to provide the Dental Council with your current postal, residential and practice addresses. However, your address, phone, fax and email details can only be published if you agree.

The personal information that appears on the public Dental Register will also be made available to the Ministry of Health for inclusion in the Health Practitioner Index (HPI). The Dental Council may provide the Ministry with further personal information about you such as your date of birth or gender, if the Ministry requires this information to verify your identity under the HPI. This may be necessary, for example, if there are two or more health practitioners who have the same name. Such further information will be given to the Ministry only on an individual basis and only if the Dental Council is satisfied that your privacy is protected. This information will not be published or disclosed to any others. You have a right to request access to, and correction of, personal information about you held by the Dental Council.

Do you want your address details published on the dental register?

Yes (please specify):             Postal                             Practice                             Residential

No, do not publish my details

Do you want your contact details to be published on the Register?

Yes (please specify):             Email and/or                     Phone and/or                     Fax

No, do not publish my details

### Verification of Identity

Any person authorised by the law of your country of residence to administer an oath there for the purpose of a judicial proceeding to complete the following:

**I certify that I have compared the attached one recent passport sized photograph and the photograph in**

Passport No \_\_\_\_\_ Issued by \_\_\_\_\_

with the applicant before me and that in my opinion they are a true and faithful likeness and I am satisfied that the applicant before me is the person to whom the identification relates. I have certified the copies of the applicant's documentation as true copies of the original documents sighted and have certified the attached photograph as a true and faithful likeness of the person before me. I make this solemn declaration conscientiously believing the same to be true and by virtue of the Oaths and Declarations Act 1957.

Signed \_\_\_\_\_ Date \_\_\_\_\_

Title \_\_\_\_\_

**Please note** that all documentation where identification verification is required should be **certified by the same person**, as authorised by the law of your country of residence to administer an oath for the purpose of a judicial proceeding; which include your passport photo, copies of your identification pages, verification of identity section of this form (p7) and the statutory declaration section of this form (p9).

**Payment**

- Cheque (must be payable to the Dental Council and must be drawn on a New Zealand trading bank)
- Credit card (provide details below)

Type of Card	<b>VISA / MASTERCARD (ONLY)</b>		
Name on Card			
Expiry date			
Card number	<input type="text"/>	<input type="text"/>	<input type="text"/>
Fees	<b>Registration</b>	All	\$357.78 <input checked="" type="checkbox"/>
<b>Upon registration each candidate must choose one of the following options (APC or Retention) and will be charged accordingly:</b>			
Fees	<b>Annual Practising Certificate (APC)</b>	Dentist & Dental Specialist	<input type="checkbox"/> \$764.62
		Dental Hygienist	<input type="checkbox"/> \$318.64
		Dental Therapist	<input type="checkbox"/> \$442.77
		Orthodontic Auxiliary	<input type="checkbox"/> \$315.07
		Dental Technician	<input type="checkbox"/> \$466.98
		Clinical Dental Technician	<input type="checkbox"/> \$466.98
	<b>Retention</b>	Dentist, Dental Specialist, Hygienist, Therapist, Orthodontic Auxiliary, Technician & Clinical Technician	<input type="checkbox"/> \$110.40
Signature			

**Statutory Declaration**

The information you give in this application is the subject of a statutory declaration to be sworn by you under the Oaths and Declarations Act 1957. If you provide false or misleading information the Dental Council can cancel your registration; you may also be subject to a fine or upon conviction, a term of imprisonment. Applicants should complete the application carefully and honestly.

Your declaration must be made before a person authorised in your country to administer an oath for the purpose of statutory proceedings.

In New Zealand a statutory declaration can be made before a barrister or solicitor, a Court Registrar, a notary public, or a Justice of the Peace. In other countries statutory declarations can be made before a Judge or a notary public.

*Jurat Stamp*

**I SOLEMNLY AND SINCERELY DECLARE** that I am the person named in the attached documents, and that the information I have provided in this application form is true and correct.

I understand that the information that I have provided is to be used by the Dental Council and its agents for the purposes of considering my application and may be disclosed to agents of the Council for these purposes.

I understand that the Council is authorised to obtain further information from me or any person or organisation concerning this application under the Health Practitioners Competence Assurance Act 2003 and consent to the collection of such information by the Council or its agents. I further understand that although the provision of any information by me is voluntary, if I refuse to provide any information this may affect the Council's consideration of my application.

I understand that I am entitled to access the information held by the Council regarding this application by a request in writing and that I may request correction of any information which is not correct.

I understand that registration with the Dental Council is necessary before I am permitted to practise as an oral health professional in New Zealand.

**I understand that under the Health Practitioners Competence Assurance Act 2003, my registration may be cancelled if I make a false or misleading representation or declaration (whether oral or written). Other penalties may also apply if I make a false declaration.**

I make this solemn declaration conscientiously believing the same to be true and by virtue of the Oaths and Declarations Act 1957.

Applicant's signature \_\_\_\_\_ Date

**Declared at** \_\_\_\_\_ **on this** \_\_\_\_\_ **day of** \_\_\_\_\_ **201\_**\_\_\_\_\_

In the presence of

\_\_\_\_\_

\_\_\_\_\_

Title

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**PLEASE REMEMBER TO KEEP COPIES OF YOUR APPLICATION FORM AND ALL ACCOMPANYING DOCUMENTS.**

**PLEASE NOTE THAT ALL INCOMPLETE APPLICATIONS WILL BE RETURNED TO THE APPLICANT.**