

# Application for registration in New Zealand for newly qualified graduates – 2017

THIS FORM IS VALID UNTIL 20 APRIL 2018

- This application is to be used by 2017 graduates (undergraduate or postgraduate) of New Zealand qualifications who are seeking registration in New Zealand.
- Please print all answers clearly.
- Please submit all supporting documents with your application to the Dental Council. Incomplete applications will be returned.
- Please remember to keep copies of your application form and all accompanying documents.
- This application is only valid until 31 March 2018. If you want to register after this period, please visit [www.dcnz.org.nz](http://www.dcnz.org.nz) to download the correct application form, or contact the dental Council at [inquiries@dcnz.org.nz](mailto:inquiries@dcnz.org.nz) for assistance.

<b>Name</b>	
Given names	Family name
Other names <sup>1</sup>	Title
If your name differs from the name displayed on your dental qualification or on any previous Dental Council documentation; and you have not previously submitted evidence to support the name change, please indicate below the reason for the name change and <b>attach certified</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(s) of practice that you <b>hold a prescribed New Zealand qualification for</b> , and in turn are seeking <b>registration in</b> . (To confirm that you hold a prescribed qualification please refer to the Dental Council website: <a href="http://dcnz.org.nz/i-want-to-practise-in-new-zealand/">http://dcnz.org.nz/i-want-to-practise-in-new-zealand/</a> )
<input type="checkbox"/> <b>General dental</b>
<input type="checkbox"/> <b>Dental specialist</b> (Please only tick if you hold a prescribed specialist qualification)
<input type="checkbox"/> Endodontic <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
<input type="checkbox"/> <b>Oral health therapy</b>
<input type="checkbox"/> <b>Dental technology</b>
<input type="checkbox"/> <b>Clinical dental technology</b>

<sup>1</sup> If you practise under a common use name, instead of your legal name, this name can be included in your name details on the register of practitioners as an “other name”. Having common use names listed on the register helps to avoid confusion when members of the public attempt to verify a practitioner’s registration status using the public register.

### Contact details

Section 140 of the Health Practitioners Competence Assurance Act 2003 requires that all registered practitioners keep the Dental Council informed of their current postal, residential and, if relevant, practice addresses. The Dental Council sends most of its communications by email. All written communications will be sent to your postal address.

<b>Postal address</b>	<b>Residential address</b> (if different from your postal address)	<b>New Zealand practice address</b> (if known)
	<i>Street</i>	<i>Street</i>
<i>Suburb</i>	<i>Suburb</i>	<i>Suburb</i>
<i>City</i>	<i>City</i>	<i>City</i>
<i>Postcode</i>	<i>Postcode</i>	<i>Postcode</i>
<i>Country</i>	<i>Country</i>	<i>Country</i>
<b>Phone</b>	<b>Phone</b>	<b>Phone</b>
<b>Mobile</b>	<b>Mobile</b>	<b>Mobile</b>
<b>Fax</b>	<b>Fax</b>	<b>Fax</b>
<b>Email</b>	<b>Email</b>	<b>Email</b>

### 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 register of practitioners registered with the Dental Council 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 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 the 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      or       Practice      or       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

### Mental or physical conditions

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

#### Transmissible major viral infections (TMVI)

Please **attach** an original typed and signed laboratory report on your serological status as related to the viruses listed below:

- Human immunodeficiency virus (HIV)
- Hepatitis B (HBV)
- Hepatitis C (HCV).

The laboratory report must include the following:

- Serological test results for **HIV** (HIV antibody and HIV antigen), and
- Serological test results for **HCV** (Hepatitis C antibody), and
- Serological test results for **HBV** (HBV surface antigen and HBV surface antibody) OR evidence of immunity to **HBV** (Absence of HBV antigen, and HBV antibodies > 10IU/L) by way of an original typed and signed report which includes serological test results for HBV, from a laboratory as listed below.

You must ensure that the test request form includes a request for your identity to be verified against your passport photograph, in the "clinical details" section, and your passport number is recorded on the form.

The report must be from one of the laboratories listed below:

- A New Zealand registered International Accreditation New Zealand (IANZ) laboratory
- An overseas laboratory which is party to a mutual recognition arrangement with the IANZ
- A laboratory registered to provide services for New Zealand Immigration.

Please note that the report must be less than **three months** old at the time of receipt. The only exception to this is that past evidence of hepatitis B immunity (absence of surface antigen with a surface antibody of  $\geq 10$  IU/L), from a laboratory listed above, will be accepted.

If you have a positive test result, your application will be referred to the Council's TMVI Panel. The Panel will request further testing to inform its recommendation to the Council about your fitness to register as an oral health practitioner in New Zealand. The Council will decide on your eligibility for registration.

All registered oral health practitioners must comply with the obligations set in the Council's Transmissible major viral infections (TMVI) practice standard available on our website at <http://dcnz.org.nz/i-practise-in-new-zealand/standards-framework/>

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 laboratory 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? (including traffic offences involving alcohol and/or drugs)

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.

**Please note** that all documentation where identification verification is required must 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, and the *Statutory Declaration* section of this form (page 5).

### Identification

Please **attach** certified copies of the identification pages of your current passport, including the signature page, to confirm your identity. If you are a New Zealand citizen, you may substitute a certified copy of your current New Zealand driver's licence in place of the identification pages of your passport.

**Please note** if a certified copy of your identification has not been provided with this form, or the form of identification provided has expired, your application will be returned as incomplete.

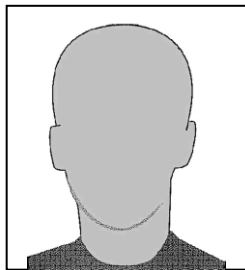
Birthplace (including country)	Date of birth (day, month, year)
Gender (please tick) <input type="checkbox"/> Male <input type="checkbox"/> Female	

### Certified photograph

When submitting your application for registration you are required to provide with your application one certified colour passport-size photograph of yourself for the purpose of identification. The photograph must not be older than three months. **Please note** that applications that do not include a properly certified photograph will be returned as incomplete.

Certification on the reverse side of the photograph must include: the signature of the certifying officer, clearly printed full name of the certifying officer, and the date. The following statement must also be included: "I certify that this is a true likeness of [applicant's full name]." (See below)

**FRONT**



**BACK**

**I certify that this is a true likeness of**  
**[applicant's full name].**

*[Signature of certifying officer and printed full name of certifying officer]*

*[Date]*

**Attach 1 certified passport photo here.**

### Verification of identity (to be completed by the same person taking your statutory declaration on page 5)

I \_\_\_\_\_ (full name) confirm that I have compared the attached one recent passport sized photograph of the applicant and the photograph in the applicant's identification document, being-

Identification type (select one):

- Passport No.....
- New Zealand driver's licence No.....

Date of expiry \_\_\_\_/\_\_\_\_/\_\_\_\_  
                          Day           Month           Year

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 identification 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.

Signed \_\_\_\_\_

Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
                  Day           Month           Year

Title \_\_\_\_\_

**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, under the Health Practitioners Competence Assurance Act 2003, be liable on conviction to a fine of up to \$10,000. **Applicants are cautioned to 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 and being the same person who completed the *Verification of Identity* section of this form (page 4).

**I SOLEMNLY AND SINCERELY DECLARE THAT:**

1. I am the person named in the attached documents, and the information I have provided in this application form is true and correct.
2. I understand the information I have provided is to be used by the Dental Council and its agents for the purpose of considering my application and such information may be disclosed to agents of the Council for such purpose.
3. I understand 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 I 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.
4. I understand I am entitled to access the information held by the Council regarding this application by a request in writing and I may request the correction of any incorrect information.
5. I understand registration and a current annual practising certificate with the Dental Council is necessary before I am permitted to practise as an oral health professional in New Zealand.
6. **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.**

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

Sign your declaration in front of an authorised witness from the list below.

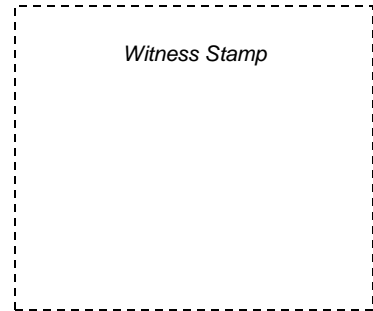
Applicant's signature \_\_\_\_\_

Declared at \_\_\_\_\_ on \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Place Day Month Year

In the presence of

\_\_\_\_\_  
Signature of authorised witness

\_\_\_\_\_  
Witness full name



**Witness title:**

Authorised witnesses may differ depending on where the statutory declaration is made: in New Zealand, another Commonwealth country, or a non-Commonwealth country. **Please select your witness title from the following options**

**In New Zealand**

- Enrolled barrister and solicitor of the High Court of NZ
- Justice of the Peace
- Notary Public
- Court Registrar or Deputy Registrar
- Member of Parliament

**In other Commonwealth countries**

- Solicitor of the High Court of New Zealand
- Justice of the Peace
- Notary Public
- Judge
- Commissioner of Oaths
- Commonwealth representative
- Other person authorised by the law of your country to administer an oath there for the purpose of a judicial proceeding).  
Please specify title:  
.....

**In non-Commonwealth countries**

- Solicitor of the High Court of New Zealand
- Notary Public
- Judge
- Commonwealth representative

## 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	<table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> </tr> </table>																				

### Fees (all fees are in NZ\$ and include GST of 15%)

**PLEASE NOTE: If you already hold a current, New Zealand APC, your APC fee may differ slightly from the one listed below. Please contact [inquiries@dcnz.govt.nz](mailto:inquiries@dcnz.govt.nz) for more information.**

**Upon registration each candidate must choose one of the following options (APC or retention) and will be charged accordingly:**

<b>Fee A</b>	<b>Registration</b>	All	<input checked="" type="checkbox"/> \$ 546.16
<b>Fee B</b>	<b>APC (including disciplinary levy)</b>	Dentist & dental specialist	<input type="checkbox"/> \$1201.15
		Dental hygienist & orthodontic auxiliary	<input type="checkbox"/> \$ 846.53
		Dental therapist	<input type="checkbox"/> \$ 913.87
		Oral health therapist	<input type="checkbox"/> \$ 940.75
		Dental technician & clinical dental technician	<input type="checkbox"/> \$ 848.48
	<b>Retention</b>	Dentist & dental specialist	<input type="checkbox"/> \$ 126.68 (1 October 2017-30 September 2018)
		Dental hygienist, dental therapist, oral health therapist, dental technician, clinical dental technician & orthodontic auxiliary	<input type="checkbox"/> \$ 129.21 (1 April 2018-31 March 2019)
<b>Total amount payable (A &amp; B)</b>			
<b>Cardholder signature</b>			

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.

## Checklist

Have you:

- Checked your application form and ensured it has been correctly completed?
- Included the correct payment by cheque or, if paying by credit card, has the cardholder signed the *Payment* section and accurately provided all credit card details?
- Attached an original typed and signed laboratory report with Hepatitis C and HIV serological status (not older than 3 months), **and** evidence of Hepatitis B immunity, or HBV serological status (not older than 3 months)
- If relevant, attached supporting documentation concerning any change of name; mental or physical condition; conviction; and/or conduct/character matter?
- Ensured that the **same** 'authorised person' has:
  - Certified a copy of your identification document?
  - Signed your recent photograph?
  - Signed the *Verification of Identity* section of the form, page 4?
  - Witnessed your *Statutory Declaration*, page 5?
- Included a certified copy of your current passport (including the signature page) or New Zealand driver's licence (NZ citizens only)?
- Attached a certified recent (less than three months) passport-size photograph of you?
- Signed the *Statutory Declaration* on page 5?