

Assessment of eligibility for registration in New Zealand for holders of non-prescribed qualifications seeking individual assessment under s.15(2) of the Health Practitioners Competence Assurance Act 2003

NOVEMBER 2017

- This application is to be used by holders of non-prescribed qualifications who are applying for an individual assessment of the equivalence of their qualifications, training and experience to a prescribed qualification.
- Please print all answers clearly.
- Please submit all supporting documents with your application. Incomplete application will be returned.
- In addition to your original application, please also submit two copies of your application and certified supporting documentation with this original application.

Name	
Given names	Family name
Other names	
If names differ from those on your dental qualification, please tick box to show reason, and attach evidence.	
<input type="checkbox"/> Marriage <input type="checkbox"/> Deed poll <input type="checkbox"/> Common use <input type="checkbox"/> Other (explain)	

Scopes of practice													
Please select the scope of practice and any additional scopes of practice which you are seeking registration in.													
<input type="checkbox"/> General dental													
<input type="checkbox"/> Dental specialist <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; border: none;"><input type="checkbox"/> Endodontics</td> <td style="width: 50%; border: none;"><input type="checkbox"/> Oral and maxillofacial surgery</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Oral medicine</td> <td style="border: none;"><input type="checkbox"/> Oral pathology</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Oral surgery</td> <td style="border: none;"><input type="checkbox"/> Orthodontic</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Paediatric dentistry</td> <td style="border: none;"><input type="checkbox"/> Periodontic</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Prosthodontic</td> <td style="border: none;"><input type="checkbox"/> Public health dentistry</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Restorative</td> <td style="border: none;"><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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*You may have exclusions placed upon your practice, depending on your training and experience. Please see the Dental Council website www.dcnz.org.nz for further information.

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 the majority of communication by email. Physical mail will be sent to your postal address.

Postal address	Residential address (if different from your postal address)	New Zealand practice address (if known)
Street	Street	Street
Suburb	Suburb	Suburb
City	City	City
Postcode	Postcode	Postcode
Country	Country	Country
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 or to sit any part of the New Zealand dental registration examinations?

Yes No

If yes, please provide your registration/application/candidate number (if known)

First dental qualification

Please provide details of the primary dental qualification upon which you are basing your application, and **attach** certified copies of:

- the diploma or degree certificate and internship certificate, where applicable.
- academic transcript/statement of marks/record of study
- course content/prescription/syllabus material
 - the full curriculum leading to the award of the qualification (current at the time of the award)
 - details of the minimum duration of training (whole time equivalent) leading to the award of this qualification
 - details of the mode(s) of assessment for this qualification, e.g. examination and clinical assessment.

If the documentation is not in English, you must provide a full translation. The translation must be prepared and certified by an official translation service.

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

Post-graduate qualifications – relevant to specialist registration

Please provide details of the post-graduate dental qualifications upon which you are basing your application, and **attach** certified copies of:

- the diploma or degree certificate
- evidence of registration status of the qualification
- academic transcript/statement of marks/record of study
- course content/prescription/syllabus material
- details of entry criteria for the specialist qualification
- the full curriculum leading to the award of the qualification (current at the time of the award)
- details of the minimum duration of training (whole time equivalent) leading to the award of the specialist qualification
- details of where the training for the specialist qualification took place, e.g. hospital, community setting
- details of the supervision of the training including names and qualifications of supervisors
- details of the mode(s) of assessment for the specialist qualification, e.g. examination and clinical assessment
- details of research activity, including time committed to research and research outcome

If the certificate is not in English, you must provide a full translation. The translation must be prepared and certified by an official translation service.

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

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/councils where registration is, or has been held in the last seven years.

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

Licensing examinations

Please provide details of any relevant licensing or registration examinations you have sat (including the New Zealand dental registration examinations). Please attach a certified copy of your results.

Country	Examination	Exam Date	Result

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 – general practice

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).

Practice experience - specialists

Please **include a copy of your curriculum vitae** with your application, ensuring that this document provides full details of:

- your relevant work experience and current employment; and
- the extent of your clinical experience in the range of tasks delineated in the specialist dental scope of practice; and
- the CPD you have undertaken in the past three years, in particular CPD relevant to the specialist scope of practice; and
- published articles or research.

You are also required to submit a logbook consisting of two parts:

1. Summary of cases treated

This portion of the logbook should include relevant patient details, clinical condition/diagnosis, treatment provided and the length of follow up/success. The logbook should demonstrate the full range of specialist work.

2. Case examples

This section should include a write up of at least five to six cases which should demonstrate the range of treatment in the speciality. This should contain (while protecting the privacy of the patient) such things as the reason for the visit, history of present complaint, medical history, dental history, patient attitude and expectation, full extra and intra oral examination and charting, special test reports, problem list/diagnosis, treatment plan and treatment provided and follow up details. It should be supplemented with relevant radiographs, clinical photographs and charting.

Practice experience – general practice continues		
<i>Please note:</i> in addition to providing the original research and logbook documentation you will need to provide two additional copies of your research and log book material.		
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) 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/assets/Uploads/Forms/Registration-forms/Referee-report.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	Relationship to applicant
Name	Relationship to applicant

Competence in English

The Dental Council considers that effective English and communication skills are a pre-requisite to practising as an oral health practitioner in New Zealand. Without the necessary communication skills the informed consent and active participation of the patient may be jeopardised. You are required to demonstrate that you can comprehend and communication in English to an acceptable standard. If English is not your first language; and you haven't completed your undergraduate dental training in New Zealand, Australia, United Kingdom, USA, Eire or Canada where English is the sole language of instruction and assessment, you must sit and pass a Council-approved language competency test. The Council's English language policy <http://www.dcnz.org.nz/assets/Uploads/Policies/English-competence-and-English-tests-policy.pdf> provides details on the approved English language tests.

Is English your first language (i.e. spoken from birth)?

Yes No

Was your undergraduate dental training completed in English, with English being the sole language of instruction and assessment and in a country where English is the first and prime language?

Yes No

Within the last **two** years have you passed a Council-approved English language test to the required level?

Yes No

If English is not your first language, and your oral health training was not completed in English you must sit and pass a Council-approved language competency test to the required level and **attach** a copy of your English test result to this application.

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.

Mental and physical condition

You are required to disclose any mental 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 ≥ 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

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

New Zealand Conditions of Practice – overseas qualified practitioners

The Dental Council expects all registered oral health practitioners to have an understanding of the cultural, social and legislative framework for the delivery of care in New Zealand. Accordingly, overseas qualified oral health practitioners are required to read and familiarise themselves with the New Zealand Conditions of Practice (NZCOP) Handbook, an online resource of the Dental Council prior to registration.

<http://www.dcnz.org.nz/resources-and-publications/publications/new-zealand-conditions-of-practice-handbook/>

Please note that all documentation where identification verification is required must be certified by the same person, as authorised to take your statutory declaration and listed in the authorised witness list on page 9 of this form. Identification documentation includes your passport photo, copies of your identification pages, *verification of identity* and *statutory declaration* sections of this form.

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.

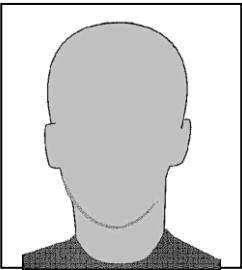
Please note if a certified copy of your identification has not been provided with this form, or the form of identification provided has expired, your application will be returned as incomplete.

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 eligibility 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	
	<p>I certify that this is a true likeness of [applicant's full name].</p> <p>[Signature of certifying officer and printed full name of certifying officer]</p> <p>[Date]</p>	<p>Attach 1 certified passport photo here.</p>

Verification of identity (to be completed by the same person taking your statutory declaration on page 9)

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 your application may be declined or the Dental Council may 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 an authorised witness from the list below. Please note authorised witnesses may differ depending upon the country in which your declaration is made.

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 may seek further information from me, or any person or organisation, concerning this application and I consent to the collection. 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.

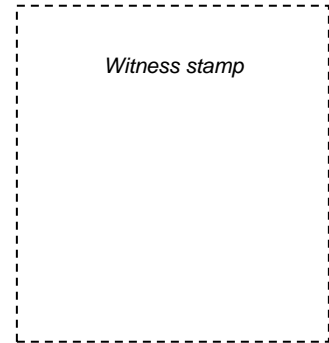
Applicant's signature _____

Declared at _____ on _____ / _____ / _____
Place Day Month Year

In the presence of

Signature of authorised witness

Authorised witnesses full name



Authorised witness:

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

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	VISA / MASTERCARD (ONLY)		
Name on card			
Expiry date			
Card number	<input type="text"/>	<input type="text"/>	<input type="text"/>
Amount NZ\$	Fees	Amount	
	Application for assessment of eligibility to be registered under section 15(2) of the Act	NZ\$ 3,505.14	
	Resubmission of application for assessment of eligibility under section 15(2) of the Act	NZ\$ 3,145.11	
	<i>Specialist qualifications ONLY (fees below)</i>		
	Application for assessment of eligibility to be registered under section 15(2) of the Act	NZ\$ 4,616.23	
	Resubmission of application for assessment of eligibility under section 15(2) of the Act	NZ\$ 3,145.11	
Cardholder signature			

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.