

# Application for eligibility to undertake supervised orthodontic auxiliary duties whilst completing a prescribed orthodontic auxiliary training programme

March 2018

- This application is to be used by unregistered persons, who are seeking approval to undertake supervised orthodontic auxiliary duties whilst completing a prescribed orthodontic auxiliary training programme.
- Please print all answers clearly.
- Please submit **all** supporting documents with your application. All certification must only be done by a person, as authorised by the law of your country of residence to administer an oath for the purpose of a judicial proceeding.
- Incomplete applications will **not** be accepted and will be returned.
- All trainees **must** obtain confirmation of a Council-approved supervisor **prior** to performing any clinical activities.

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

<b>Contact details</b>	
<p>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.</p>	
Postal address	Alternative contact address
Phone	Phone
Mobile	Mobile
Fax	Fax
Email	Email

<b>Previous registration applications</b>
<p>Have you previously applied for registration with the Dental Council or to sit any part of the New Zealand dental registration examinations?</p> <p> <input type="checkbox"/> Yes                      <input type="checkbox"/> No             </p>
<p>If yes, please provide your registration/application/candidate number (if known):</p>

Level 11, 109-125 Willis Street, Wellington, 6011 | PO Box 10-448, Wellington, 6143, New Zealand  
 T: +64 4 499 4820 | F: +64 4 499 1668 | E: [inquiries@dcnz.org.nz](mailto:inquiries@dcnz.org.nz)

### Dental qualifications

Please provide details of your qualifications and **attach certified** copies of the diploma or degree certificate. 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

### 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

Have you completed 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

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.

### 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  $\geq 10$  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 current 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?

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.

**Confirmation of enrolment**

Please attach a **certified** copy of your enrolment in the certificate of orthodontic assisting, Academy of Orthodontic Assisting (Trapezio Course).

**Confirmation of supervising dentist(s)/dental specialist(s)**

I confirm that my supervising dentist(s)/dental specialist(s) is:

Name: \_\_\_\_\_ Registration number: \_\_\_\_\_

Name: \_\_\_\_\_ Registration number: \_\_\_\_\_

I confirm that I have **attached** a letter from my supervising dentist(s)/ dental specialist(s) that details:

- their qualifications and experience to act in this supervising role; and
- their understanding that they must be onsite at all times to advise, guide, monitor, participate or intervene in all procedures undertaken by myself; and
- their confirmation that all patients/guardians will be aware of, and consent to, providing orthodontic auxiliary care while undergoing training; and
- their understanding that they must inform the Dental Council in circumstances where your practice may pose a risk to patients.

Yes

No

**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 4 of this form. Identification documentation includes your passport photo, copies of your identification pages and the *verification of identity* section 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.

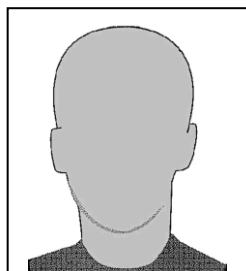
Birthplace (including country)	Date of birth (day, month, year)
Gender (please tick) <input type="checkbox"/> Male <input type="checkbox"/> Female	

**Certified photograph**

When submitting your application for eligibility to undertake supervised orthodontic auxiliary duties whilst completing a prescribed orthodontic auxiliary training programme 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 \_\_\_\_\_

## Declarations

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 of New Zealand 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 \_\_\_\_\_

### To be signed by the supervising dentists(s)/dental specialist(s)

I solemnly and sincerely declare that:

To the best of my knowledge the information recorded in this application is true and correct. I have **attached** a letter detailing:

- my qualifications and experience to act in the supervising role
- my understanding that I or another Council approved supervisor must be onsite at all times to advise, guide, monitor, participate or intervene in all procedures undertaken by the applicant
- my confirmation that all patients/guardians will be aware of, and consent to, the applicant providing orthodontic auxiliary care while undergoing training.
- my agreement to inform the Dental Council in circumstances where the applicant's practice may pose a risk to patients.

Supervisor's signature: \_\_\_\_\_ Date: \_\_\_\_\_

Supervisor's signature: \_\_\_\_\_ Date: \_\_\_\_\_

**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		
Card number	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
Expiry date		
	Fee payable until 31 March 2018	Fee payable after 1 April 2018
Amount NZ\$	<input type="checkbox"/> \$ 107.08	<input type="checkbox"/> \$ 109.22
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.