Application for registration in an additional scope of practice

APRIL 2018

- This application is to be used by registered practitioners intending to be registered in an additional scope of practice.
- The information and fees contained in this form are correct as at the above date. Please note fees are subject to change – you can check the current fee schedule on our website at www.dcnz.org.nz/resources-and-publications/resources/fees
- Please print all answers clearly.
- Please submit **all** supporting documents with your application. Incomplete applications will be returned.

Registration number	

Name	
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 **attach** evidence. ☐ Marriage ☐ Deed poll ☐ Common use ☐ Other (explain)	

Scopes of practice
Please tick the additional scopes of practice in which you are applying for registration
General dental therapy ☐ Adult care
Clinical dental technology ☐ Implant overdentures in dental technology

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

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. All written communications 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**

Dental qualifications and training

Please provide details of your qualifications and training relevant to the additional scope(s) of practice you are applying for, and **attach** certified copies.
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

Practice experience (only complete this question if you have a prescribed qualification in the scope for implant overdentures)

For application in the clinical dental technology scope of practice for the additional scope for implant overdentures please provide details of your clinical experience relevant to the additional scope(s) of practice you are applying for registration in **and** include copies of at least eight documented cases and a competency attestation from an appropriately qualified dentist or dental specialist.

Employer	Full or part time and number of hours per week	Dates

Practice experience – (only complete this question if you have a non-prescribed qualification in any of the additional scopes of 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).

Please provide case examples -

- This section should include a write up of at least eight cases which should demonstrate the range of treatment in the area of your application. 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 supporting documentation such as radiographs, clinical photographs and charting.

Details	Location	Date

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 5 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.

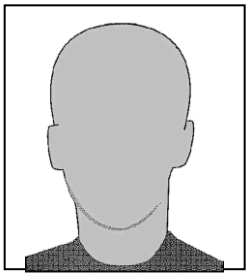
Birthplace (including country)	Date of birth (day, month, year)
Gender (please tick) ☐ Male ☐ Female	

Certified photograph

When submitting your application for registration in an additional scope of practice 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 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 _____

Witness Stamp

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	☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐☐	
Amount NZ$	Application for registration with a **prescribed** qualification in an additional scope of practice	☐ $ 546.16
	Application for registration with a **non-prescribed** qualification in an additional scope of practice	☐ $ 844..40
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.