College of Dental Technologists of Alberta

#304-13220 St. Albert Trail
Edmonton, AB T5L 4W1

Application for Restricted Activities Authorization

Before completing this application, please ensure that you have met the education and eligibility requirements to apply for restricted activities authorization, including reviewing and understanding the legislation, standards of practice any other information related to the restricted activities that Dental Technologists and Dental Technicians may be authorized to perform per the *Health Professions Restricted Activity Regulation (HPRAR)* .

Applicants must complete ALL sections of this form and attach the required supporting documentation. **Incomplete applications will not be processed. Incomplete applications will be closed after 30 days.**

1. Applicant Information

Name: ____________________

Home Address: ____________________

City: __________ Postal Code: __________

Email: ____________________

Home Phone: __________ Work Phone: __________

Date of Birth: __________ CDTA #: __________

2. Educational Information

Name of Educational Institution Attended:

____

Address of Institution:

____

Date of Couse Completion:

____

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Type of Course:	• Diploma/Degree	• Continuing Education Course
Please indicate which of the required supporting documents below are included with your application.		
• Evidence of successful completion of appropriate diploma/degree education. (i.e. Official transcript)		
• Evidence of successful completion of a Council-approved[1] continuing education course.		

3. Declaration

I attest by my signature below that all the information provided in this application is correct, accurate, and complete to the best of my knowledge. I understand that any false or misleading statement, omission, or misrepresentation may result in the rejection of the application.

I understand that the information I have provided may be verified by the CDTA and I authorize the CDTA to seek additional information from third parties including but not limited to educational institutions, regulatory bodies, employers, or any other course deemed required to process my application. I authorize any and all such sources to release such information to the CDTA.

<u>I am aware that I must not perform any Restricted Activities for which I have applied until I have been notified, in writing, that my application has been approved.</u>

I acknowledge that, once authorized, I must adhere to the established Standards of Practice and any Guidelines and/or Policies relevant to performing restricted activities. These may change from time to time, and I am responsible for maintaining current knowledge of these documents.

Applicant Signature	**Date**

[1] https://www.nait.ca/nait/continuing-education/courses/dhse200-patient-care-and-ipc-for-ohcps

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4. Payment Information

Insurance Premium: $85.00

Type:
- Visa:
- Mastercard:
- Visa Debit:

Credit Card #: **Expiry:**

Cardholder Name:

Cardholder Signature:

Applicants are required to submit the application form and supporting documents to membersinfo@cdta.ca

Please contact us before you visit the College office as we work both off-site and in-person. We want to ensure that when you visit, we are available to assist you. Staff is available by appointment only.