

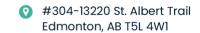
Application for Restricted Activities Authorization

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 <u>Health Professions Restricted Activity Regulation (HPRAR)</u>.

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

	lame:		
	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:		





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-approved¹ 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

Restricted Activities Authorization Application Last updated: May 2023

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



4.

Payment Information					
Insurance	e Pre	mium: \$85.00			
Туре:	•	Visa: Mastercard: Visa Debit:			
Credit Card #:			Expiry:		
Cardholder Name:					
Cardhol	der	Signature:			

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

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.