COLLEGE OF DENTAL TECHNOLOGISTS OF ALBERTA

REGULATED MEMBER/RESTRICTED ACTIVITIES AUTHORIZED TECHNOLOGIST/TECHNICIAN
AUTHORIZATION FORM

Restricted Activities: are activities carried out in relation to or as part of providing a health service and may only be provided by authorized individuals. These activities are listed in Schedule 7.1 of the *Government Organization Act*. A regulated member who has completed training approved by the Council in dental asepsis and patient-care responsibilities **may** be authorized by the Registrar to perform the following restricted activities for the purpose of **colour matching or determining a preliminary fit**:

- fitting fixed or removable partial or complete dentures;
- fitting fixed or removable orthodontic or periodontal appliances;
- fitting implant-supported prostheses;
- fitting removable full dentures, if the regulated member has successfully completed a practical examination in removable full prostheses;
- fitting removable partial dentures, if the regulated member has successfully completed a practical examination in removable partial prostheses;
- fitting fixed partial dentures, if the regulated member has successfully completed a practical examination in fixed partial prostheses;
- fitting fixed or removable orthodontic and periodontal appliances, if the regulated member has successfully completed a practical examination in fixed and removable orthodontic and periodontal appliances.

I, _____, hereby make application for restricted activities authorization
(Name of Regulated Member)
in accordance to the Dental Technologists Profession Regulation under the *Health Professions Act* and Schedule 7.1 of the *Government Organization Act.* I have read and understood my scope of practice under the *Health Professions Act, The Dental Technologists Profession Regulation and the Government Organization Act.* I will not perform any restricted activities that are not within my individual scope of practice as authorized by the CDTA.

Applicant's Signature_____Date:_____

RESTRICTED ACTIVITY MANDATORY PROGRAMMING REQUIREMENTS (*must be approved by Council*):

□ Dental Asepsis Certificate □ Client Care (Patient Care) Responsibilities Certificate

**Please attach a copy of your certificate(s) to this application*

Method of Payment

Errors and Omissions Insurance Premium: $ 85.00

□ Visa □ MasterCard

Credit Card #_____ Expiry _____

Cardholders' Name: _____Cardholders Signature: _____

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