



## REFERENCE FORM FOR DENTAL THERAPISTS FOR DENTAL THERAPY LICENSE IN THE NORTHWEST TERRITORIES

*PLEASE RETURN COMPLETED FORM TO:*

**Office of the Registrar, Professional Licensing, Health & Social Services  
Box 1320- 8th Floor Centre Square Tower- Yellowknife, NWT X1A 2L9  
Telephone: (867) 920-8058 Facsimile: (867) 873-0484**

NAME OF APPLICANT (**PLEASE PRINT**):

*I authorize the referee to disclose to the Registrar, Professional Licensing of the Northwest Territories, information relevant to licensure that would otherwise be confidential and I waive any right of disclosure of the same and agree that communication between the Registrar and the referee shall be privileged. This personal information is being collected under authority of the Dental Auxiliaries Act. It is protected by the privacy provisions of the Access to Information and Protection of Privacy Act.*

SIGNATURE OF APPLICANT:

DATE:

NAME OF REFEREE (PLEASE PRINT):

APPLICANT TELEPHONE/FACSIMILE #:

**INSTRUCTIONS FOR REFEREE:** Your personal knowledge of this applicant is important in judging suitability for licensure. Any problems or concerns that you identify below should be explained. Please use the back of this form if required.

1. Indicate dates where, and in what capacity, you worked with the applicant. Must be within the last three years.

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**YES    NO**

- |  |                          |                          |
|--|--------------------------|--------------------------|
| 2. Are you aware of any problems regarding the applicant's physical or mental health or of any alcohol or drug problems?                                       | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Are you aware of any complaints regarding the applicant from patients, dentists, or other dental therapists?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you know of any ethical problems the applicant has which relate to dental therapy practice?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Are you aware of any aspects of the applicant's personality that may cause difficulties in professional interpersonal relationships?                        | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Is there any reason why you would not consider the applicant to have adequate knowledge, skills, and judgement required to provide dental therapy services. | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you any additional information with respect to the applicant's professional or ethical conduct that may affect their application for registration?     |                          |                          |

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SIGNATURE OF REFEREE:	DATE:
ADDRESS:	
TELEPHONE #:	FACSIMILE #:

**The Reference may fax this to the above number but ensure original is mailed promptly.**