

| Personal Information (Check the appropriate box. If answer is yes to any of the following questions, provide full explanation/details on a separate sheet of paper.) | Yes | No |
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| 1. Have you ever been refused a license, permit or registration to practice dentistry in any jurisdiction? | | |
| 2. Have you ever had a license, registration or right to practice in any jurisdiction revoked, suspended or restricted in any way? | | |
| 3. Are you presently the subject to an allegation, complaint or investigation for any reason whatsoever by any licensing authority? | | |
| 4. Are you aware of any inquiry likely to be made by any authority, licensing or otherwise, with respect to your conduct, personal behavior or competence? | | |
| 5. Have you ever been convicted of an indictable offence for which you have not been pardoned? If yes, specify, when, where and what charge. Attach particulars. | | |
| 6. To your knowledge, do you currently have any contagious or infectious disease? | | |
| 7. Have you previously applied for, or have been issued, a license or certificate of registration in the Northwest Territories. If yes, indicate year, if known? License # (if known) | | |

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| <p>Declaration</p> <p>I authorize the Dental Registration Committee to investigate and obtain from any person or persons, such information as may be required in relation to this application. I certify that the statements made by me in this application are true and complete. I am aware that misrepresentation or falsification may result in rejection of my application or withdrawal of registration.</p> <p>Signature: _____ Date: _____</p> | |
| <p>When complete, forward with required attachments, to: Registrar, Health Professional Licensing Department of Health & Social Services Government of the Northwest Territories 8th Floor Centre Square Tower (5022-49 ST) P.O. Box 1320, YELLOWKNIFE, NT X1A 2L9 Telephone: (867) 920-8058</p> | <p>If paying your fees by Visa or MasterCard, complete the following: (See list of requirements for fees.)</p> <p>Name on Card: _____ Card Number: _____ Card Expiry Date: _____ Amount: _____</p> <p>Authorized Signature: _____</p> |

This personal information is being collected under the authority of the *Dental Profession Act* of the NWT and will be used to process Application for Registration. The information is protected by the privacy provisions of the *Access to Information and Protection of Privacy Act* of the NWT. If you have any questions about the collection, contact the Registrar's Office at the above address.