ASSOCIATION of CANADIAN FACULTIES of DENTISTRY | L'ASSOCIATION des FACULTÉS DENTAIRES du CANADA

APPLICATION FORM

FOR GRADUATES OF DENTAL PROGRAMS NOT APPROVED BY THE COMMISSION ON DENTAL ACCREDITATION OF CANADA

Please type or print the following information exactly as you wish it to appear on all ACFD/AFDC documents

Note: For those applying to the Qualifying Program or Degree Completion Program, please contact the Universities directly for all admission and/or residency requirements.

Any false statement knowingly made in this document by the applicant will result in rejection of the application and/or cancellation of examination eligibility and/or cancellation of any previously issued results.

Family Name: ____________ Given Names: ____________

Street Address: ____________

City: ____________ Province/State: ____________

Postal Code: ____________ Country: ____________

Telephone (Res.): ____________ Fax: ____________

Telephone (Bus.): ____________ E-Mail: ____________

Has your name been changed? ☐ Yes ☐ No

If so, give date and details of change with notarized photocopies of documents:

____

____

ACFD OFFICE USE ONLY

Identification #: ____________ Registration: ____________

Payment Amount Received: $____________ for ☐ Application fee ☐ Examination fee

DENTAL EDUCATION

I have attended the following dental faculties or schools (give length and dates)

I have received the following diploma(s)/degrees(s). (List diploma(s)/degree(s) and give the name of the university with dates awarded/to be awarded) *

I hereby make application to take the Eligibility Examination of The Association of Canadian Faculties of Dentistry in accordance with, and subject to, its rules and regulations.

I certify that the preceding declaration and information supplied in this questionnaire is true and I authorize all necessary verification. I authorize the Association of Canadian Faculties of Dentistry to release my results to universities offering a Qualifying Program or Degree Completion Program.

Signature of applicant

This signature must be witnessed by an officer of a Canadian Consulate or Embassy, a Notary Public or a Commissioner of Oaths.

I declare that I have witnessed this document being signed by the individual shown in the accompanying photographs, which I have verified and signed.

Signature of Witness (Seal)

Title

Address

Date

THE FOLLOWING MUST ACCOMPANY THE COMPLETED APPLICATION FORM.

1. Notarized (bearing an original notarial seal and signature in English or French) copies of dental diploma(s)/degree(s) in the language issued and a notarized copy of a certified translation into English or French, if required.

   * A notarized copy of any internship certificate or equivalent in the language issued and a notarized copy of a certified translation into English or French, if required, must be provided if applicable to the requirements of the dental faculty or school attended.

2. An official transcript or a notarized copy of the transcript of the applicant's record from all dental schools or faculties attended stating the results obtained throughout all years of the course in the language issued and a notarized copy of a certified translation into English, if required.

3. Application and examination fee **(Canadian funds only)**.

4. Two identical unmounted photographs showing a full front view of head and shoulders without a hat taken against a white background. The photograph must be an original, printed on high quality paper. The photographs must have maximum dimensions of 50 mm X 70 mm and minimum dimensions of 43 mm X 54 mm. The name and address of the photographer and the date the photograph was taken must appear on the back of the photographs. The photographs must have been taken in the last twelve months. The individual who witnesses your signature on the application form must also certify that the photograph is a true likeness and sign the back of the photographs.

   Example of back of photograph

   Photo Co. Ltd.
   110 Any Street
   Any Town, Country

   Photo Taken on
   Date

   I certify this to be a true likeness of *Applicant Name*

   Witness Signature

Please indicate your

Preferred examination date: ____________

Preferred language: ☐ English ☐ French

Preferred examination centre: ____________

NOTE:

1. **Applicants who have previously been registered for the Eligibility Examination are not required to provide a new application form, the application fee or the required documentation. Please forward only a written request to be registered along with the examination fee.**

2. No registrations will be accepted for the examination if received **AFTER** the Application Deadline Date.

3. Requests by Candidates to change an examination centre **MUST** be received in writing to the ACFD office prior to the Application Deadline Date.

4. Requests by Candidates to change preferred examination language **MUST** be received in writing to the ACFD office prior to the application Deadline Date.

Forward your completed Application Form and Fee to:
ACFD
100 Bronson Avenue, Suite 204
Ottawa, ON K1R 6G8
Canada