



ASSOCIATION of CANADIAN  
FACULTIES of DENTISTRY



L'ASSOCIATION des FACULTÉS  
DENTAIREs du CANADA

**PRIOR LEARNING ASSESSMENT (PLA)  
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 a Qualifying Program or Degree Completion Program, please  
contact the universities directly for all admission, language 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 of program and dates)

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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) \*

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I have been licensed as a dentist in the following jurisdiction. (Provide dates and license/ registration number)

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I hereby make application to participate in the Prior Learning Assessment process 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.

I authorize World Education Services to verify the authenticity of all documentation provided to the Association of Canadian Faculties of Dentistry for the purpose of participation in the Prior Learning Assessment.

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

**NOTE:**

1. Applicants who have previously been approved for candidacy with the ACFD are not required to provide the application fee or previously submitted documentation. Please forward a completed application form along with the applicable 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**

**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. Notarized copies of dental licenses/ registrations from all jurisdictions.
4. Application and examination fee (**Canadian funds only**).
5. 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 <u>Date</u>
I certify this to be a true likeness of <u>Applicant Name</u>
<u>Witness Signature</u>

**Please indicate your**

**Preferred examination date:** .....

**Preferred language:**

English     French

**Preferred examination centre:** .....