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

APPLICATION FORM

FOR GRADUATES OF NON-ACCREDITED DENTAL SPECIALTY PROGRAMS

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

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.

My specialty is

- Dental Public Health ☐
- Endodontics ☐
- Oral and Maxillofacial Radiology ☐
- Oral and Maxillofacial Surgery ☐
- Oral Medicine/ Oral Pathology ☐
- Orthodontics ☐
- Pediatric Dentistry ☐
- Periodontics ☐
- Prosthodontics ☐

Family Name: ____________ Given Names: ____________

Street Address: ____________

City: ____________ Province/State: ____________

Postal Code: ____________ Country: ____________

Telephone (Res.): ____________ Fax: ____________

Telephone (Alt.): ____________ 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 #:	
Specialty:	
School:	
Payment (CAD):	
Registration:	

DENTAL EDUCATION

I have completed the following dental and dental specialty programs. Please provide start and end dates.

Name of Program	Institute	Start Date dd/mm/yr	End Date dd/mm/yr

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

THE FOLLOWING MUST BE SUBMITTED WITH THIS APPLICATION FORM

1. Original notarized copies of transcripts from all dental and dental specialty programs;
2. Original notarized copies of the degree/diploma/certificate from all dental and dental specialty programs;
3. Original certified translations of all transcripts and diplomas/degrees/certificates into English or French if required;
4. Completed self evaluation checklist for the applicant's specialty;
5. Application and Examination fee made to the order of ACFD (Canadian funds only);
6. 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.**

NOTE:

Original notarized copy means, bearing the original seal and/or signature of a Notary Public or Commissioner of Oaths who can attest to seeing the original document.

Applications, required documentation, fees, and Requests for Registration must be received by the ACFD office by the application deadline date. Regardless of postmark or pickup date, any application, documentation, or Requests for Registration that fails to meet this requirement will not be processed.

The Confirmation of Graduation form must be received by the ACFD office in a sealed envelope from the university that issued your specialty diploma by the application deadline date.

It is the applicant's responsibility to ensure that the application is completed properly and submitted with all of the required documentation within the prescribed deadlines.

Mail all of the required documentation to:

ACFD
100 Bronson Avenue, Suite 204
Ottawa, ON K1R 6G8
Canada

DECLARATION

I hereby make application to take the Dental Specialty Core Knowledge 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 Dental Specialty Assessment and Training Programs.

I understand and accept that there are a very limited number of places in the Dental Specialty Assessment and Training Programs and that acceptance into one of these programs is not guaranteed.

I understand that my application will be rejected if the required documentation is incomplete.

I authorize the Association of Canadian Faculties of Dentistry or its agents to verify the authenticity of all documentation for the purpose of participation in the Dental Specialty Core Knowledge Examination.

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 ....

F:\ACFD\Info Pkg\DSCKE\English\DSCKE-APPLICATION FORM 2010 DRAFT.doc