



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 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	<table border="1" style="border-collapse: collapse; width: 50px; height: 100px;"> <tr><td> </td></tr> <tr><td> </td></tr> <tr><td> </td></tr> <tr><td> </td></tr> <tr><td> </td></tr> <tr><td> </td></tr> <tr><td> </td></tr> <tr><td> </td></tr> <tr><td> </td></tr> <tr><td> </td></tr> </table>										

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 you have answered yes, you must provide a **notarized** photocopy of your proof of name change in the language issued and an original certified translation into English or French if required.

ACFD OFFICE USE ONLY	
Identification #:	_____
School:	_____
Payment (CAD):	_____
Registration:	_____

DENTAL EDUCATION

I have completed the following dental and dental specialty programs. The start date and graduation date for each program is required.

Name of Program (BDS/DDS/Masters etc.)	University	Start Date dd/mm/yy	Graduation Date dd/mm/yy

Preferred exam date: _____

Language: English French

Preferred exam site: _____

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 _____ Date _____

Address _____

THE FOLLOWING MUST BE SUBMITTED WITH THIS APPLICATION FORM

1. Original **notarized** photocopies of the degree/diploma/certificate from all dental and dental specialty programs and original certified translations into English or French if required.
2. If the program requires the completion of a compulsory rotating internship prior to issuing the final diploma, an original **notarized** photocopy of the internship completion certificate is required, as well as an original certified translation into English or French.
3. If the transcripts are going to be provided by the University in a language other than English or French, an original certified translation is 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.**

THE FOLLOWING MUST BE RECEIVED DIRECTLY FROM THE UNIVERSITY FROM WHICH THE APPLICANT RECEIVED THE DEGREE.

1. Original official transcripts of marks, from all dental and dental specialty programs, sent directly from the University in a sealed envelope.
If your official transcripts will be provided in a language other than English or French, you must provide an original certified translation bearing the original seal and signature of a certified translator.
2. Confirmation of Graduation form. The Confirmation of Graduation form must be downloaded from the ACFD website. Section 1 is to be completed by the applicant, Section 2 is to be completed by the University that awarded the **specialty degree**. The Registrar or equivalent at the University must sign and seal the form, confirming the information, and return it directly to the ACFD in sealed envelope.

NOTE:

Notarized means the photocopied document has been compared to the original by the individual who has signed and sealed the document. All notarized photocopies must bear the original seal and signature of a Notary Public, a Commissioner of Oaths, or an Officer of a Canadian Consulate or Embassy. The seal/notary statement must state that the document is a true copy of the original document seen by the individual who has notarized the 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 and the official transcript of marks must be received by the ACFD office in a sealed envelope from the university that issued your specialty diploma by the application deadline date.

Mail all of the required documentation to:

ACFD
PO Box 618, Station B
Ottawa, ON K1P 5P7

For courier packages only:

80 Elgin Street, 2nd Floor
Ottawa, ON K1P 6R2