



*Government of Bermuda*  
 Ministry of Health, Seniors and Environment  
 OFFICE OF THE CHIEF MEDICAL OFFICER

Bermuda Dental Board

**DENTAL TECHNICIANS REGULATIONS 1950**

**APPLICATION FOR INITIAL REGISTRATION AS A DENTAL TECHNICIAN**

**SECTION I: APPLICATION STATEMENT**

I hereby make application to be licensed and to have my name entered in the Register of Dental Technicians maintained by the Bermuda Dental Board under the Dental Technicians Regulations 1950, and I do hereby declare that, to the best of my knowledge and belief, the particulars hereunder are true.

\_\_\_\_\_  
 Signature of Applicant

\_\_\_\_\_  
 Date

**SECTION II: PARTICULARS OF APPLICANT**

1. NAME: \_\_\_\_\_  
First Middle Last

2. ADDRESS: \_\_\_\_\_

3. TELEPHONE: \_\_\_\_\_ EMAIL: \_\_\_\_\_

4. DATE OF BIRTH: \_\_\_\_\_ AGE: \_\_\_\_\_  
DD/MMM/YYYY

5. NATIONALITY: \_\_\_\_\_

6. PROFESSIONAL DIPLOMAS OR OTHER QUALIFICATIONS (with dates of grant):

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

7. Particulars (if any) of striking off, or removal, from any dental/dental technicians register, **or of any disciplinary action taken by any dental authority** \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_

8. Particulars (if any) of any conviction of any offence as a result of which a sentence of imprisonment was imposed without the option of a fine. \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_

**SECTION III: VERIFICATION OF INFORMATION**

I verify that the statements in this application are true and correct to the best of my knowledge, information and belief. I understand that false statements may result in the revocation of my registration.

Dated this \_\_\_\_ day of \_\_\_\_\_ 20 \_\_\_\_ Signature of Applicant \_\_\_\_\_

**Dental Tech Registration Fee** - A cheque or money order for **BD\$150.00** (US\$150.00) made payable to **THE ACCOUNTANT GENERAL**.

**Please forward completed application to:** The Office of the Chief Medical Officer, Council for Allied Health Professions, P.O. Box HM1195, Hamilton HM EX, Bermuda, or hand deliver to Ministry of Health, Continental Building – Ground Floor, 25 Church Street, Hamilton HM 12.

**REQUIRED DOCUMENTATION**

The following documents must accompany this application:

1. **Letter of Employment from Bermudian Employer** (applies to non-Bermudians only)
2. **Letter of Professional Reference** from two previous employers/supervisors (most current and discipline specific), (on letter head & dated)
3. **Statement of Experience** (C.V./Resume) - (education and employment with dates)
4. **Certificate of Good Standing** – on official letterhead (an original from the jurisdiction that you have been registered in for the past two years).

**Along with original documents or notarised copies of the following:**

5. **Diplomas and Postgraduate Certificates(s) or Letter of Proof of Qualification** (Graduation) from relevant learning institution in English (issued in country of registration)

<b>FOR OFFICIAL USE ONLY</b>				
FEE PAID	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
RECEIPT NO.	_____			APPLICATION APPROVED <input type="checkbox"/>
SIGNATURE OF DENTAL REGISTRATION OFFICE: _____			DATE:	_____
<b>COMMENTS:</b> _____				
<b>MEETING MEMBERSHIP:</b>				
	<u>NAME</u>	<u>PRESENT</u>		<u>DATE</u>
		<u>YES</u>	<u>NO</u>	
<b>BOARD CHAIRMAN</b>	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
MEMBER	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
MEMBER	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
MEMBER	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
MEMBER	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____