



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

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**Bermuda Dental Board**

**DENTAL HYGIENIST REGULATIONS 1950**

**A – APPLICATION FOR INITIAL REGISTRATION AS A DENTAL HYGIENIST**

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

Dated this \_\_\_\_\_ day of  
\_\_\_\_\_, 20 \_\_\_\_

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

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**B - PARTICULARS TO BE FURNISHED BY APPLICANT**

1. SURNAME: \_\_\_\_\_

2. FULL CHRISTIAN NAMES: \_\_\_\_\_

3. ADDRESS: \_\_\_\_\_  
\_\_\_\_\_

3b. EMAIL: \_\_\_\_\_

4. AGE: \_\_\_\_\_

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 hygienist 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. \_\_\_\_\_  
\_\_\_\_\_

## 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 Hygienist Registration Fee** - A cheque or money order for **BD\$150.00** (US\$150.00) made payable to the **ACCOUNTANT GENERAL**.

### REQUIRED DOCUMENTATION

The following documents must accompany this application:

1. Offer letter from Bermuda employer (applies to non-Bermudians only)
2. Letter of Reference from two previous employers/supervisors (most current and discipline specific), (on letter head & dated)
3. Statement of Professional Experience (c.v.) - (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)

**Please forward completed application to:** Office of the Chief Medical Officer, Bermuda Dental Board, P.O. Box HM1195, Hamilton HM EX, Bermuda, or hand deliver to the Office of the Chief Medical Officer, Continental Building 25 Church Street, Hamilton HM 12.

<b>FOR OFFICIAL USE ONLY</b>			
FEE PAID	<input type="checkbox"/>	YES	<input type="checkbox"/>
			NO
RECEIPT NO. _____	<input type="checkbox"/>	<b>APPLICATION APPROVED</b>	<input type="checkbox"/>
SIGNATURE OF DENTAL REGISTRATION OFFICE: _____		<b>APPLICATION NOT APPROVED</b>	<input type="checkbox"/>
			DATE: _____
<b>COMMENTS:</b> _____			
<b>MEETING MEMBERSHIP:</b>			
	<u>NAME</u>	<u>PRESENT</u>	<u>DATE</u>
		<b>YES</b>	<b>NO</b>
<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"/>