CDSS LICENSE DECLARATIONS

License Declarations

Associated Clinics / Facilities

Associated Clinics Registration

Final Approval

INCOMPLETE FORMS WILL BE SUBJECT TO THE SAME PENALTY AS LATE PAYMENT

In the past 12 months, have you had a change of practice?

Are you a permanent resident of Saskatchewan (residing in Saskatchewan more than 183 days a year)?

Are you a faculty member at the University of Saskatchewan or Saskatchewan Polytechnic?

Are you licensed to practise dentistry in any other jurisdictions? \*

In the past 12 months, have any complaints, investigations, discipline proceedings, and or fitness to practice inquiries been made against you alleging professional / academic misconduct or incompetence in any jurisdiction? \*

In the past 12 months, has any license entitling you to practice dentistry been suspended or revoked in any jurisdiction? \*

In the past 12 months, have you had any professional liability insurance settlements in any jurisdiction?

In the past 12 months, have you been found guilty of negligence, malpractice, or incompetence in a Superior Court? \*

In the past 12 months, have you been convicted of a criminal offence? \*

Are you aware of any injury, dependency, infection, disorder or other condition that would impair your ability to practice safely and competently? \*

Have you read and understood the CDSS Good Character Standard?

Have you read and understood the CDSS Code of Ethics and the CDSS Regulatory Bylaws Part 9.2?

I understand that I must attend and co-operate fully with the Quality Assurance Committee, Professional Conduct Committee, or Discipline Committee following notification by the College.

I understand I must comply with all the prescribed obligations, terms, and conditions of any agreement or program concluded in the course of an assessment or investigation during quality assurance, professional conduct, and discipline with the College.

Do you have any outstanding fee, debt, obligation, or condition owed to the College?

Will your professional liability insurance be provided by CDSPI? \*

Are you current with the CDSS Continuing Education Policy requirements for the past 3 years?

Is your life support training current? \*

Have you read and understood the CDSS Informed Consent Process Standard?

Have you read and understood the CDSS Infection Prevention and Control Standard? \*

Have you read and understood the CDSS Advertising Guidelines? \*

What level of sedation do you practice: \* None Minimal Moderate Deep

Have you read and understood the CDSS Sedation and General Anesthesia Standard.

Is there a Cone Beam Computed Tomography (CBCT) unit in the facility where you practice?

Have you read and understood the CDSS Radiation and Imaging Standard?

Do you intend to incorporate neuromodulators in your practice?

Have you read and understood the CDSS Advanced Facial Esthetic Therapies and Adjunctive Considerations Standard?

 Are you a faculty member at the U of S? \*

Indicate languages other than English in which you can provide services:

Are you affiliated with more than one dental facility in Saskatchewan? \*

Associated Clinics / Facilities

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The clinics below are already associated with your account, if you’d like to fill your license renewal with existing details, click "Add".

To add multiple existing clinics, you will need to click "Add" and then "Save and add another Facility" for each one.

If you'd like to add a new clinic, type the name of the clinic into the form to search registered clinics.

If your clinic is brand new and not available yet, please contact the CDSS at cdss@saskdentists.com.

For technical support please contact saskdentists@5by5.ca

Choose from your associated clinics / facilities

Or Type below to add a facility

If your clinic is brand new and not available yet, please contact the CDSS at cdss@saskdentists.com.

Name of Facility:

 (Clear Form)

(As it appears publicly in external advertising.)

Address of Facility:

(Include complete mailing address and if different, include street address as well.)

Facility Ph #:

Facility Fax #:

Afterhours Ph #:

Website:

Is this facility owned by a non-CDSS member?:

Indicate your relationship to this facility (Choose one only):

--select--

Do you practice at this location?

 Yes

 No

Are you the Comprehensive Authorized Practice Director at this location?

 Yes

 No

\*\*Comprehensive Authorized Practice Director\*\* means: the primary attending full practicing member, at a facility / clinic, will have the primary responsibility for the oversight of the comprehensive authorized practice carried on within that facility / clinic. This oversight includes:

providing current practice contact information;

acting as the most responsible member and contact at a facility / clinic for quality assurance purposes, in the public interest;

the general safety of practice in the facility / clinic;

reporting of critical incidents;

the appropriate employment of, or contracting with, Assistants, Therapists and Hygienists;

the supervision, which may vary depending upon circumstances, of comprehensive authorized practices performed at the facility / clinic pursuant to sections 15(2), and 23 of The Act, these bylaws and the CDSS Member Competence and Professional Practice Standard;

obtaining required Facility / Clinic Registration and developing protocols regarding, but not limited to, Sedation and Anesthesia, Radiation and Imaging, Employment and Business Relationships, Agreements and Leases, Advertising, Quality Assurance, Patient Records and other legal requirements.;

Note: If you are solely a referral / consultant dentist, you are not an Authorized Practice Director unless it is part of your contract. Referral / consult dentists must list the organization contact information, but not all clinic sites.

Name of Facility:

SOURIS FAMILY DENTAL

(As it appears in external advertising.)

Address of Facility / Clinic: (Click here to edit)

1905 1ST AVE NE WEYBURN SASKATCHEWAN S4H 0A1 CANADA

(Include mailing address, if different)

Facility / Clinic Website:

SOURISDENTAL@SOURISDENTAL.COM

Facility / Clinic Ph #:

306-842-8111

Facility / Clinic Owner(s):

 Add more

DENTALCORPORATION OF CANADA

Facility / Clinic Email:

SOURISDENTAL@SOURISDENTAL.COM

Using the same email address as another CDSS member will result in not having access to the member-side of the CDSS website.

Please be aware that the preferred email address you provide will be used to distribute: CDSS Alerts, e-Newsletters, Continuing Education

Notices/Invitations, and potentially personal and/or confidential information from the College of Dental Surgeons of Saskatchewan.

Which CDSS member(s) (or section 25 agency) employs the dental hygienists, therapists, and assistants at this facility / clinic?

DR. LARRY PODOLSKY

Indicate your relationship to this facility (Choose one only):

Associate

I confirm that the dentist(s) and owner(s) of this facility / clinic are aware of and are compliant with CDSS Practice of Dentistry, Clinic Facility Standard sections 7 and 8, and CDSS Bylaws 3.8, 3.9 and 3.10.

 Yes

 No

Does each CDSS member connected to this facility have access to their patient records?

 Yes

 No

I, as Clinic Director, agree to read, understand and communicate the CDSS Practice of Dentistry Clinic Facilities Standard to all staff within this facility / clinic before any DDAs23 authorized practice is performed to allow the practice of dentistry within this facility / clinic. I have emphasized the following:

Advertising Standard

 Yes

 No

Sedation Standard

 Yes

 No

Workplace Waste Management and Environmental Standards

 Yes

 No

Radiation Standard

 Yes

 No

Infection Prevention and Control Standard

 Yes

 No

I understand that I must apply for Sedation Registration before any procedures involving sedation are performed in this facility / clinic and that each member performing sedation must have Sedation Registration.

 Yes

 No

I understand that if general anesthesia will be performed by a CPSS licensed physician in this facility / clinic, that an inspection will be performed for accreditation as non-hospital treatment facility, pursuant to the Health Facilities Licensing Act.

 Yes

 No

I agree to provide the CDSS with a written protocol for the continuity of care when any of the dentists practicing in the facility / clinic, take leave from, or discontinue their connection with this clinic (educational clinics exempted).

 Yes

 No

I agree to notify the CDSS within 24 hours of any changes to the above information on this permit.

 Yes

 No

Comprehensive Authorized Practice Director:

AASEN, KEVIN

I,

KEVIN AASEN

, HEREBY MAKE APPLICATION to continue as a registrant member of the College of Dental Surgeons of Saskatchewan as provided under the Dental Disciplines Act of Saskatchewan.

If granted a license to practice dentistry in Saskatchewan, I solemnly promise and undertake to faithfully and truly submit and conform to and obey, all bylaws, standards and orders of the College of Dental Surgeons of Saskatchewan and that I will practice the profession in accordance with the Dental Disciplines Act.

Every false statement knowingly made, or connived, by a dentist in any clause of this license renewal is good cause for the rejection of the renewal or for revocation of license.

AFFIDAVIT: I ,

KEVIN AASEN

, make this solemn declaration believing all statements in this application to be true and knowing that it is of the same force and effect if made under oath and by virtue of the Canada Evidence Act, 1893.

Date: