



7. PLACE AND COUNTRY OF BIRTH: .....

8. PERMANENT ADDRESS: (address to appear in the Register and for forwarding notices)

.....

..... POSTCODE .....

Is this your residential address? YES  NO

If "Yes" do you agree that it be available for public inspection on the Register? YES  NO

If you do not tick any of these boxes, and the address above is not a P.O. Box, an address will NOT appear against your name in the Register accessible by the Public.

9. CONTACT DETAILS:

Telephone: Day ( ) ..... After Hrs ( ) .....

Email Address: (if available) .....

10. CATEGORY/IES OF REGISTRATION APPLIED FOR

Dental Therapist

Dental Hygienist

11.(a) STATE/TERRITORY OF REGISTRATION TO CURRENTLY PRACTISE ELSEWHERE AS A DENTAL THERAPIST:

Please specify all Australian States and Territories in which you hold registration that gives you legal authority to currently carry on the occupation of dental therapist.

New South Wales .....  
Australian Capital Territory .....  
Northern Territory .....  
Victoria .....  
Tasmania .....  
South Australia .....  
Western Australia .....

Go to 11(b) if you specified  
any of these States or  
Territories

11.(b) As documentary evidence of my legal authority to currently carry on the occupation of dental therapist in the State/ Territory of \_\_\_\_\_, I attach from that State/Territory, my current Annual Practising Certificate which is:

- the original YES  NO
- a complete and accurate certified copy of the original YES  NO

12.(a) STATE/TERRITORY OF REGISTRATION TO CURRENTLY PRACTISE ELSEWHERE AS A DENTAL HYGIENIST:

Please specify all Australian States and Territories in which you hold registration that gives you legal authority to currently carry on the occupation of dental hygienist.

New South Wales .....  
Australian Capital Territory .....  
Northern Territory .....  
Victoria .....  
Tasmania .....  
South Australia .....  
Western Australia .....

Go to 12(b) if you specified  
any of these States or  
Territories

12.(b) As documentary evidence of my legal authority to currently carry on the occupation of dental hygienist in the State/ Territory of \_\_\_\_\_, I attach from that State/Territory, my current Annual Practising Certificate which is:

- the original YES  NO
- a complete and accurate certified copy of the original YES  NO

13. Year of first registration as a dental auxiliary in the Australian State or Territory from which Mutual Recognition is sought .....

14. Please state the qualification or other method on which your registration is based in the Australian State or Territory in which you currently practise.

.....

15. My Qualifications are:

QUALIFICATION	INSTITUTION	YEAR

16. In any Australian State or Territory or Overseas place, are you subject to disciplinary proceedings or any preliminary investigations or action that might lead to disciplinary proceedings in relation to your practice as a dental auxiliary? YES  NO

17. In any Australian state or Territory or Overseas place, is your registration cancelled or currently suspended as the result of disciplinary action? YES  NO

18. In any Australian State or Territory or Overseas place, are you personally prohibited from carrying on the practice of dentistry as a dental auxiliary? YES  NO

19. In any Australian State or Territory or Overseas place, are you subject to any special conditions in carrying out practice as a dental auxiliary as a result of criminal, civil or disciplinary proceedings? YES  NO

20. In any Australian State or Territory or Overseas place, are you subject to any special conditions in carrying on practice as a dental auxiliary? YES  NO

If yes to any questions from 16 - 20, please specify details:

.....  
.....

I, ..... (full name) hereby apply for registration as a dental auxiliary in Queensland pursuant to the provisions of the *Mutual Recognition Act 1992* and do solemnly and sincerely declare that the information given is true and correct in every particular. I consent to the Dental Board of Queensland making enquiries of, and exchanging information with, the authorities of any Australian State or Territory regarding my practice as a dental auxiliary or otherwise regarding matters relevant to this application.

And I make this solemn declaration conscientiously believing same to be true and by virtue of the provisions of the *Statutory Declarations Act 1959*.

.....  
Signature of Applicant

Taken and Declared before me at

..... this ..... of .....  
(place) (day) (month) (year)

.....  
Signature of Justice of the Peace/ Commissioner  
for Declarations/ Notary Public or Lawyer  
(Delete whichever not applicable)

# Dental Board of Queensland

PLEASE ADDRESS ALL CORRESPONDENCE TO -

THE REGISTRAR  
DENTAL BOARD OF QUEENSLAND  
G.P.O. BOX 2438  
BRISBANE QLD 4001

ABN: 33663105895

8<sup>TH</sup> FLOOR  
FORESTRY HOUSE  
160 MARY STREET  
BRISBANE QLD 4000

TELEPHONE: (07) 3225 2508  
FACSIMILE: (07) 3225 2527  
E-Mail Address:  
dental@healthregboards.qld.gov.au  
IN REPLY PLEASE QUOTE  
NO.

REGISTRATION PAYMENTS

## TAX INVOICE

### FOR CREDIT CARD PAYMENTS

please complete the credit card authority below

Credit Card Payments (Visa (excluding Visa Electron\*), Mastercard or Bankcard) are accepted through mail, by facsimile or personal payment at counter **ONLY**.

For this payment to be accepted you must complete all sections below.

VISA

MASTERCARD

BANKCARD

CREDIT CARD NUMBER

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EXPIRY DATE

CARDHOLDER'S NAME  
(Print)

CARDHOLDER'S  
SIGNATURE

**AMOUNT**

\$ \_\_\_\_\_ (GST Exempt)

payment to the Dental Board of Queensland

purpose of payment----

CONTACT PHONE NUMBER - .....

### ***PAYMENT MAY ALSO BE MADE -***

1. BY CHEQUE OR MONEY ORDER made payable to the respective health professional Board. DO NOT send cash by post. Payment **must** be in Australian dollars. We cannot accept payment in foreign currency or foreign cheques or by direct Bank Transfer.
2. AT SECRETARIAT OFFICE [address above] by cheque, money order, credit card, debit card or cash. office hours - Monday to Friday 9.00 am to 4.00 pm.

\*Visa Electron Cards can not be accepted for mail payments.

Mutual Recognition Application for a Dental Auxiliary - Form MR D411 - October 2004 Version-revised May 2009