

FORM No. TTMR DA311

| <b>DENTAL BOARD OF QUEENSLAND</b> |   |   |
|-----------------------------------|---|---|
| GPO Box 2438<br>BRISBANE Q 4001   | 8th Floor<br>Forestry House<br>160 Mary Street<br>BRISBANE 4001 | Phone: (07) 3225 2508<br>Facsimile: (07) 3225 2527<br>E-mail: <a href="mailto:dental@healthregboards.qld.gov.au">dental@healthregboards.qld.gov.au</a><br>Website: www.dentalboard.qld.gov.au |

**APPLICATION FOR REGISTRATION AS A DENTAL AUXILIARY IN QUEENSLAND**

**Trans-Tasman Mutual Recognition Act 1997**

**Accompanying Documents to be provided**

As part of your application please submit each of the following:

A. The original or a certified copy of your Annual Practising Certificate (or equivalent) for the current year, as evidence of the legal authority you hold to currently practise as a dental auxiliary in New Zealand.

B. Fees for Registration (Australian dollars):  
 \$254.00 - if registering between 1 January and 31 March; OR  
 \$190.00 - if registering between 1 April and 30 June; OR  
 \$380.00 - if registering between 1 July and 31 December.

These fees are exempt from the Goods and Services Tax (GST) and comprise a non-refundable application fee of \$127.00 plus a pro-rata portion of the annual registration fee of \$253.00 and only cover registration until 30 June. Renewal of registration beyond 30 June is subject to you applying between 1 May and 30 June each year for registration renewal and paying the associated annual registration fee.

[The following refund entitlements are prescribed by law under the Registration Regulation. (In all cases the application fee component of the total fees payable is not refundable.)

- Should your application for registration be refused, or you withdraw your application before it is decided, you are entitled to a refund of the pro-rata registration fee you paid.
- If you are granted registration but decide to surrender it within 3 months of it being granted, you are entitled to a proportional refund [comprising the pro-rata registration fee paid less an amount equal to the prescribed fee for registration of not more than 3 months].
- If you choose to surrender registration more than 3 months after it is granted, you are not entitled to any refund.]

C. Two recent passport-type photographs of yourself endorsed on the back by a witness as follows:  
 "I (*witness*) certify this photograph to be a true likeness of (*applicant's name*)"

and signed and dated on the back by the witness and yourself. The witness must be either:

- an adult holder of an Australian or New Zealand passport valid for more than two years and issued after 1 January 1987; or
- a person on the Australian or New Zealand Electoral Roll for the preceding 12 months.

**Qualifications recorded on the Register**

The qualifications of persons registered under Trans-Tasman Mutual Recognition are recorded on the Register as "Mutual Recognition NZ" followed by the year of initial registration in New Zealand.

**Completion of this Form**

Please use BLOCK LETTERS, tick where appropriate and ensure that all sections are completed.

**If you do not hold registration giving you legal authority to currently practise as a dental auxiliary in New Zealand, do not complete this form. Please contact the Board and an alternative application form will be provided.**

1. TITLE: (circle preferred title) **MR MRS MS MISS DR OTHER** (please specify) \_\_\_\_\_
2. LAST NAME: .....
3. GIVEN NAMES (in full): .....
4. PREVIOUS NAMES (if applicable): .....
5. GENDER: **Male**  **Female**

6. DATE OF BIRTH: .....
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). Do you hold registration that gives you legal authority to currently carry on the occupation of dental therapist in New Zealand?

YES  NO

If you answered YES, go to 11(b)

11(b). As documentary evidence of my legal authority to currently carry on the occupation of dental therapist in New Zealand, I attach my current Annual Practising Certificate which is:

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

12(a). Do you hold registration that gives you legal authority to currently carry on the occupation of dental hygienist in New Zealand?

YES  NO

If you answered YES, go to 12(b)

12(b). As documentary evidence of my legal authority to currently carry on the occupation of dental hygienist in New Zealand, I attach 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 New Zealand .....

14. Please state the qualification or other basis of your registration in New Zealand.

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15. My Qualifications are:

| QUALIFICATION | INSTITUTION | YEAR |
|---------------|-------------|------|
|               |             |      |
|               |             |      |
|               |             |      |

16. In New Zealand or 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 New Zealand or 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 New Zealand or 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 New Zealand or 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 New Zealand or 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:

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.....

.....

.....

I, .....(full name)

hereby apply for registration as a dental auxiliary in Queensland pursuant to the provisions of the *Trans-Tasman Mutual Recognition Act 1997* 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 New Zealand and 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

8TH 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.