



Dental Ed

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**MODERATE CONSCIOUS SEDATION (MODSED) FOR DENTISTS REGISTRATION  
FORM: FALL 2019 COURSE**

Fax to: 1-604-800-0487

Course start date you are registering for is September 2019 program  
Do not delay in registering. This is a limited space course. You can send in the required documents as you collect them after your initial registration and course payment.

**STUDENT DEMOGRAPHICS**

Name: \_\_\_\_\_

(As you want printed on your certificate)

Registration #: \_\_\_\_\_ Province/State of Registration: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_

Province/State: \_\_\_\_\_ Postal/Zip Code: \_\_\_\_\_ Phone: \_\_\_\_\_

Cellular: \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_

**Due to the nature of this program, full tuition fee refunds will not be given except for extreme circumstances. Visit <https://www.dentaled.com/policies.html> for further information.**



I have faxed:

- A. A copy of my current Heart and Stroke Foundation Health Care Provider CPR certificate (valid for 12 months from date of issue). This card must be Heart and Stroke Foundation of Canada. No other CPR provider is recognized (Relates to prerequisites for the ACLS course you will be completing during the program)

Yes: \_\_\_\_\_ No: \_\_\_\_\_ will send when I have taken the course

- B. A copy of my DDS/DMD active registration from my dental regulatory authority.

Yes: \_\_\_\_\_ No: \_\_\_\_\_ will send when I have collected it

- C. Proof of 5 million dollars in malpractice liability insurance.

Yes: \_\_\_\_\_ No: \_\_\_\_\_ will send when I have in place

- D. A letter of good standing from my current dental regulatory authority has been requested to be mailed to DentalEd.

Yes: \_\_\_\_\_ No: \_\_\_\_\_ will be requesting soon

## CATERING DIETARY REQUESTS

Please list and special dietary restrictions/requests that you or your staff has regarding course catering.

Name: \_\_\_\_\_ Issues/requests: \_\_\_\_\_

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**AUXILIARY TEAM MEMBER #1 (CDA/RDA/HYGEINIST/RN) REGISTRATION INFORMATION (CAN BE SENT IN AT A LATER DATE)**

Please note that this is not the registration information needed if this staff person is taking a CDAAC course. They must still fill in the main CDAAC registration form also.

Will send in at a later date: \_\_\_\_\_

Name of assistant 1: \_\_\_\_\_

Title: Dental Hygienist: \_\_\_\_\_ CDA/RDA: \_\_\_\_\_ Other: \_\_\_\_\_

Registration Number: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ Province/State: \_\_\_\_\_

Postal/Zip Code: \_\_\_\_\_

Cellular Phone: \_\_\_\_\_

Personal non-shared email: \_\_\_\_\_

Wishes to attend didactic classes and write CDAAC certification exam: Yes: \_\_\_\_\_ No: \_\_\_\_\_

✓ I have faxed a copy of my current Health Care Provider CPR certificate. Yes: \_\_\_\_\_ No: \_\_\_\_\_

✓ I have faxed a copy of my practice permit. Yes: \_\_\_\_\_ No: \_\_\_\_\_

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**AUXILIARY TEAM MEMBER #2 (CDA/RDA/HYGEINIST/RN) REGISTRATION INFORMATION (CAN BE SENT IN AT A LATER DATE)**

Please note that this is not the registration information needed if this staff person is taking a CDAAC course. They must still fill in the main CDAAC registration form also.

Will send in at a later date: \_\_\_\_\_

Name of assistant 2: \_\_\_\_\_

Title: Dental Hygienist: \_\_\_\_\_ CDA/RDA: \_\_\_\_\_ Other: \_\_\_\_\_

Registration Number: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ Province/State: \_\_\_\_\_

Postal/Zip Code: \_\_\_\_\_

Cellular Phone: \_\_\_\_\_

Personal non-shared email: \_\_\_\_\_

Wishes to attend didactic classes and write CDAAC certification exam: Yes: \_\_\_\_\_ No: \_\_\_\_\_

✓ I have faxed a copy of my current Health Care Provider CPR certificate. Yes: \_\_\_\_\_ No: \_\_\_\_\_

✓ I have faxed a copy of my practice permit. Yes: \_\_\_\_\_ No: \_\_\_\_\_

Fax to: 1-604-800-0487

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## COURSE POLICIES

- A. Due to the nature of sedation courses for dentists, tuition fee refunds will not be given except for extreme circumstances. The full tuition amount will be charged as per the original payment schedule. If you have any questions or concerns, please contact our office.
- B. The intent to withdraw from a sedation course for dentists must be communicated to the program director in writing.
- C. Supporting documentation of illness or family emergency must be submitted to the program coordinator for consideration of a full or partial refund for a sedation course for dentists within three weeks of the withdrawal notification.
- D. Salaries required to fulfill commitments to faculty members relating to your course registration are not necessarily refundable.
- E. For sedation courses with a clinical rotation, the student has one year from the date of the end of the didactic lectures to complete their clinical training. If the student exceeds the one-year time limit, then they must redo the didactic portion of the course and pay a tuition of \$9000.00 before undertaking their clinical rotation
- F. Academic misconduct such as cheating will result in immediate failure of a course and/or clinical practicum and a loss of all tuition and other associated expenses
- G. Each participant of our dental sedation courses must be aware that if they do not perform satisfactorily during the course, the course director will not write a letter to their governing body stating that they are competent in parenteral moderate sedation and airway management

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