

DENTAL COUNCIL

Ministry of Health and Wellness Frank Walcott Building, Culloden Road, St. Michael BARBADOS

Email: dental.council@barbados.gov.bb
Tel. No.: (246) 536-3800 (PBX), Fax: (246) 426-5570



Our Ref.:

Staple photo here

APPLICATION FOR REGISTRATION

l .	Please indicate by tick	ing the appropriate box:						
	(a) type of registration for which you are applying: □ Dental Practitioner □ Dental Hygienist □ Dental Technician □ Dental Auxiliary							
	(b) the status of registration for which you are applying:							
	☐ Permanent							
2.	If you are applying fo	or a Temporary or Special registration, please state the period for						
۷.		which the licence is required:						
		•						
	Year	r Month Day to Year Month Day						
3.	Please PRINT clearly in black ink							
	Name in full:	Name in full:						
	Maiden Name:							
	Marital Status:	Date of Birth:						
	Residential Address:							
	Telephone Nos.: ()()						
	Business Address:							
	-							
	Telephone Nos.: ()()						
	Email Address:							
	Country of Birth:	Country of Citizenship:						

Qualification			Name & Address of Institution	Date of Completion
	stitution.		ofessional activities engaged in intervals of inactivity over six mo	
Time P	eriod (m	onth/year)	Type of Professional Activity	Address
/	to	/		
/	to	/		
/	to	/		
/	to	/		
	to	/		
/_	to	/		
	to			
6. Lis	st of prof	essional bodi	es with which you are associated.	
Professional F			nal Bodies	Date of Affiliation
		·		to
			<u> </u>	to
_				to
				to
				to

7.	a.	a. Has a successful claim in respect of damage or injury resulting from negligence in yo									
		discharge of your professional duties ever been broug	ght against	you?		Yes 🗆 No					
	b.	Are you currently the subject of any investigation? If yes, please explain on the reverse side and attach re		□ ormat	No ion.						
8.	a.	Have you ever been convicted of a criminal offence?		Yes		No					
	b.	Are you currently the subject of any police investigation	ion?	Yes		No					
	If yes, please explain on the reverse side and attach relevant information.										
		NB: Failure to disclose this information with respect to nos. your registration/licensure.	7 and 8 sha	ll resul	lt in r	evocation of					
9.		Indicate below the reason for your application									
10.		Have you been diagnosed with any medical condition	on or phys	sical c	halle	enge which	may				
		adversely affect the practice of dentistry?	Υ□		N						
		If yes, please explain on the reverse side and attach re	elevant inf	ormat	ion.						
		I hereby certify that the above information i	is complet	e and	true						
		Signature	Date (Year /	′ Mo	nth / Day)	-				
		I acknowledge that if I make any false declarations	s:								
	My registration may be refused/revoked and/or										
		I may be charged with serious professional misconduct.									
		Signature	Date (Year /	Mor	nth / Day)	•				