




Provision of additional information for recency of practice/return to practice Profession: Dental

Part 7 Division 6 of the Health Practitioner Regulation National Law (the National Law)

This form is for dental practitioners to provide information about their recency of practice. Recency of practice requirements apply to dental practitioners, whether they are currently registered or not, who have not practised dentistry in the last five years or longer. This form can also be used to provide additional information by those wishing to return to practice after an absence or wishing to provide dental care in a new field of dentistry, change divisions, change from non-practising to practising registration or add an endorsement. It is important that you refer to the Board's registration standards, codes and guidelines when completing the form. Registration standards, codes and guidelines can be found at www.dentalboard.gov.au





 **This application will not be considered unless it is complete and all supporting documentation has been provided.** Supporting documentation **must** be certified in accordance with the Australian Health Practitioner Regulation Agency (AHPRA) guidelines. For more information, see *Certifying documents* in the *Information and definitions* section of this form.

Privacy and confidentiality

The Board and AHPRA are committed to protecting your personal information in accordance with the *Privacy Act 1988* (Cth). The ways the Board and AHPRA may collect, use and disclose your information are set out in the collection statement relevant to this application, available at www.ahpra.gov.au/privacy. By signing this form, you confirm that you have read the collection statement. AHPRA's privacy policy explains how you may access and seek correction of your personal

information held by AHPRA and the Board, how to complain to AHPRA about a breach of your privacy and how your complaint will be dealt with. This policy can be accessed at www.ahpra.gov.au/privacy.

Symbols in this form

-  **Additional information**
Provides specific information about a question or section of the form.
-  **Attention**
Highlights important information about the form.
-  **Attach document(s) to this form**
Processing cannot occur until all required documents are received.
-  **Signature required**
Requests appropriate parties to sign the form where indicated.

Completing this form

- Read and **complete all questions**.
- Ensure that **all pages** and required **attachments** are returned to AHPRA.
- Use a **black** or **blue** pen only.
- Print clearly in **BLOCK LETTERS**
- Place X in **all** applicable boxes:

SECTION A: Application inclusions

1. Which division(s) of the profession are you applying for recency of practice and/or return to practice?

Mark all options applicable to your application


- | | | |
|---|--|---|
| <input type="checkbox"/> Dentist | <input type="checkbox"/> Dental hygienist | <input type="checkbox"/> Dental prosthetist |
| <input type="checkbox"/> Dental therapist | <input type="checkbox"/> Oral health therapist | <input type="checkbox"/> Dental specialist |

2. Are you currently registered? YES NO


Mark the type of registration you currently hold

- Practising Non-practising

SECTION B: Personal details

 The information items in this section of the application marked with an asterisk (*) will appear on the public register.

3. What is your name and date of birth?

 If you have ever been formally known by another name, or you are providing documents in another name, you **must** attach proof of that change.

For more information, see *Change of name* in the *Information and definitions* section of this form.

Title* MR MRS MISS MS DR OTHER

First given name*

Middle name(s)*

Family name*

Previous names known by (e.g. maiden name)

Date of birth / /



SECTION C: Contact information

i If you are submitting an application for general registration at the same time as this Application for recency of practice/return to practice and have already provided the following contact information as part of your application for general registration, you do not need to provide it again here.

4. What are your contact details?

Provide your current contact details below – place an next to your preferred contact phone number.

Business hours **Mobile**

After hours

Email

5. What is your residential address?

i If you are not currently practising, or are not practising the profession predominantly at one address:

- your residential address will be recognised as your principal place of practice, and
- the information items marked † will appear on the public register as your principal place of practice.

Refer to the question below for the definition of principal place of practice.

Residential address **cannot** be a PO Box.

Site/Building and/or position/department (if applicable)

Address (e.g. 123 JAMES AVENUE; or UNIT 1A, 30 JAMES STREET)

City/Suburb/Town†

State or territory (e.g. VIC, ACT)/**International province†** **Postcode/ZIP†**

Country (if other than Australia)

6. Is the address of your principal place of practice the same as your residential address?

YES

NO *Provide your Australian principal place of practice below*

i Principal place of practice for a registered health practitioner is:

- the address at which you predominantly practise the profession, or
- your principal place of residence, if you are not practising the profession or are not practising the profession predominantly at one address.

Principal place of practice **cannot** be a PO Box.

The information items marked with an asterisk (*) will appear on the public register.

Site/Building and/or position/department (if applicable)

Address (e.g. 123 JAMES AVENUE; or UNIT 1A, 30 JAMES STREET)

City/Suburb/Town*

State/Territory* (e.g. VIC, ACT) **Postcode***



7. What is your mailing address? My residential address
 My principal place of practice
 Other (*Provide your mailing address below*)

Site/Building and/or position/department (if applicable)

Address/PO Box (e.g. 123 JAMES AVENUE; or UNIT 1A, 30 JAMES STREET; or PO BOX 1234)

City/Suburb/Town

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State or territory (e.g. VIC, ACT)/**International province** **Postcode/ZIP**

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Country (if other than Australia)

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SECTION D: Recency of practice/return to practice

8. Do you wish to change the type of dental care you provide? YES NO

E.g. from specialist practice to general practice.

Provide details below

You **must** attach a separate sheet with additional details that do not fit within the space provided.

9. What type of practice do you intend to return to?

For more information, see *Practice* in the *Information and definitions* section of this form.

Provide details below

You **must** attach a separate sheet with additional details that do not fit within the space provided.



10. What type of work environment do you intend to return to?

i E.g. solo practitioner, group practice, public dental clinic, public dental hospital, rural, suburban etc.

Provide details below



You **must** attach a separate sheet with additional details that do not fit within the space provided.

11. Have you practised the profession during the past five years?

YES

NO

Provide your reason for submitting this form



You **must** attach a separate sheet with additional details that do not fit within the space provided.

SECTION E: Work history

i If you are submitting an application for general registration at the **same time** as this *Application for recency of practice/return to practice* and have already provided the following detailed information about your work history as part of your application for general registration, you do not need to provide it again here.

If you are dual registered, e.g. dental hygienist and dental therapist, or applying for registration as a dentist and specialist, you must provide details about **both** areas of practice.

12. Have you already provided your work history information as part of your application for general registration?

YES **Go to Section F**

NO **Go to the next question**

13. What is your full practice history since obtaining your qualification?

Most recent position

Position

Type of practice (e.g. management, education, advisory)

Dates of employment / to /

Average hours per week Full-time Part-time

Key responsibilities

Location details

Name

Address (e.g. 123 JAMES AVENUE; or UNIT 1A, 30 JAMES STREET)

City/Suburb/Town

State (e.g. VIC, NSW, ACT)

Postcode

Business hours (phone)

Email



Previous position

Position Type of practice (e.g. management, education, advisory)

Dates of employment / to / Average hours per week Full-time Part-time

Key responsibilities

Location details

Name

Address (e.g. 123 JAMES AVENUE; or UNIT 1A, 30 JAMES STREET)

City/Suburb/Town

State (e.g. VIC, NSW, ACT) Postcode

Business hours (phone) Email

Attach a separate sheet if your work history details do not fit in the space provided.

14. Since the date you obtained your qualification have there been any breaks or gaps in your practice history, longer than six months, where you were not practising? YES NO

Provide an explanation for the breaks in your practice history (e.g. undertaking study, travel, family commitment)

You **must** attach a separate sheet with additional details that do not fit within the space provided.

15. When did you last practice?
 For more information, see Practice in the Information and definitions section of this form.

Date of last practise

/ /

16. Was this in Australia? YES NO

Specify the country(ies) you practised in below

17. Did your last practicing position involve direct patient care? YES **Go to question 20** NO **Go to the next question**



18. What was your last practicing position?

Provide details of the position and type of work you undertook. Please attach a position description if available

Form area for question 18 with horizontal lines for text entry.



You **must** attach a separate sheet with additional details that do not fit within the space provided.

19. When did you last provide direct patient care?

Date of last provided patient care

DD / MM / YYYY date input fields

20. What was your last practicing position which involved direct patient care?

Provide details of the position, including information on your scope of practice and routine clinical procedures that were undertaken

Form area for question 20 with horizontal lines for text entry.



You **must** attach a separate sheet with additional details that do not fit within the space provided.

21. On average, how many hours of clinical procedures per week did you undertake in your last role or when you last provided direct patient care?



E.g. removal of wisdom teeth, molar endodontics etc.

Provide details below

Form area for question 21 with horizontal lines for text entry.



You **must** attach a separate sheet with additional details that do not fit within the space provided.

22. What procedures did you regularly refer to other practitioners in your last role or when you last provided direct patient care?

Provide details below

Form area for question 22 with horizontal lines for text entry.



You **must** attach a separate sheet with additional details that do not fit within the space provided.

SECTION F: Qualifications

If you are submitting an application for general registration at the **same time** as this *Application for recency of practice/return to practice* and have already provided the following detailed information about your qualifications as part of your application for general registration, you do not need to provide it again here.

23. Have you already provided your qualifications information as part of your application for general registration?

YES Go to Section G

NO Go to the next question



24. What are the details of your primary registrable qualification?

Primary qualification
 Title of qualification

 Name of awarding institution (University/College/Examining body)

 Date awarded
 / /

25. Have you completed any additional study or obtained qualifications relevant to the type of dental health care you plan to provide since you ceased practice?

YES NO

Additional study and qualifications
 Title of qualification

 Name of awarding institution (University/College/Examining body)

 Date awarded
 / /
 You **must** attach a certified copy of your original academic transcript and testimony or certificate that indicates completion of the qualification mentioned in this form.

Additional study and qualifications
 Title of qualification

 Name of awarding institution (University/College/Examining body)

 Date awarded
 / /
 You **must** attach a certified copy of your original academic transcript and testimony or certificate that indicates completion of the qualification mentioned in this form.

Attach a separate sheet if all your qualification details do not fit in the space provided.

26. Have you undertaken any bridging programs or other courses in preparation for your return to practice?

YES NO

Most recent bridging program or course
 Title of course/program

 Name of institution (University/College/Organisation)

 Location of institution

 Start date / / Completion date / /
 You **must** attach a certified copy of evidence that indicates completion of the program and a course content/outline.



Additional bridging programs or courses

Title of course/program

Name of institution (University/College/Organisation)

Location of institution

Start date / / / / / Completion date / / / / /

You **must** attach a certified copy of evidence that indicates completion of the program and a course content/outline.

Attach a separate sheet if all your course details do not fit in the space provided.

SECTION G: Registration history

If you are submitting an application for general registration at the **same time** as this *Application for recency of practice/return to practice* and have already provided the following detailed information about your registration history as part of your application for general registration, you do not need to provide it again here.

27. Have you already provided your registration history as part of your application for general registration? YES **Go to Section H** NO **Go to the next question**

28. Have you been registered and practising dentistry in a country other than Australia during the time that you have not been practising in Australia? YES NO

Provide details of your current or previous registration

State/Territory/Country

Registering authority

Registration number / / / / / Type of practice

Period of registration / / / / / to / / / / /

You must attach to this application certified evidence of your current or previous registration in dentistry outside of Australia.

29. Provide details of any previous registration.

Previous registration

State/Territory/Country

Registering authority

Registration number / / / / / Type of practice

Period of registration / / / / / to / / / / /



Additional registration

State/Territory/Country

Registering authority

Registration number Type of practice

Period of registration
 / / to / /

Attach a separate sheet if all your registration history does not fit in the space provided.

SECTION H: Professional development activities

30. Have you undertaken any professional development activities, in Australia or overseas, in the five years prior to your current application for registration?

YES NO

Most recent activity

Name of course/program/activity

Name of organisation

Location of activity

Country (if other than Australia)

Type of activity (e.g. clinical/scientific, non-scientific)

Date / / Hours spent on activity (excluding breaks)
 SPECIFY

You **must** attach a certified copy of evidence of your participation, such as attendance certificates or log of activities provided by a professional association.

Additional activity

Name of course/program/activity

Name of organisation

Location of activity

Country (if other than Australia)

Type of activity (e.g. clinical/scientific, non-scientific)

Date / / Hours spent on activity (excluding breaks)
 SPECIFY

You **must** attach a certified copy of evidence of your participation, such as attendance certificates or log of activities provided by a professional association.

Attach a separate sheet if all your professional development details do not fit in the space provided.



31. What are the details of the last infection control training course you completed?


Course details

Name of course/program/activity

Name of organisation

Location of activity

Date of activity
 / /

 You **must** attach a certified copy of evidence of successful participation in the course.

32. What are the details of the last CPR training course you completed?


Course details

Name of course/program/activity

Name of organisation

Location of activity


Date of activity
 / /

 You **must** attach a certified copy of evidence of successful participation in the course.

SECTION I: Other activities relating to the practice of dentistry

33. Have you undertaken any other activities related to the practice of dentistry, or that required dental qualifications, in the past five years?

YES NO

 E.g. Employment in a health care agency or government department, professional committee, teaching or research positions.

Activities relating to dentistry

Description of activity

Location or name of organisation where activity was undertaken

Country (if other than Australia)

Dates of activity
 / to /

Number of hours spent (approx.)

Full-time Part-time



Activities relating to dentistry

Description of activity

Location or name of organisation where activity was undertaken

Country (if other than Australia)

Dates of activity: / to / Number of hours spent (approx.)
 SPECIFY

Full-time Part-time

Attach a separate sheet if all your activity details do not fit in the space provided.

34. How have you maintained your involvement and connection with the profession?

E.g. list organisations you have been and are currently affiliated with, membership of professional associations, professional networks etc.

Provide details of your circumstances below

.....

You **must** attach a separate sheet with additional details that do not fit within the space provided.

SECTION J: Compliance with regulatory requirements

35. When you were previously registered with a dental board in a state or territory of Australia, did you comply with all requirements for registration?

YES NO

Provide details of your circumstances below

.....

You **must** attach a separate sheet with additional details that do not fit within the space provided.

36. When you were previously registered with a dental board in a state or territory of Australia, were there any findings made against you after a disciplinary hearing?

YES NO

Provide details below

.....

You **must** attach a separate sheet with additional details that do not fit within the space provided.



37. Have you read and understood the registration standards, codes, guidelines and policies of the Board that are relevant for general registrants?

YES

NO

The Board's codes, guidelines and policies are available at www.dentalboard.gov.au

Mark all the registration standards, codes, guidelines and policies that you have read

Registration standards

- Dental continuing professional development registration standard
- Dental criminal history registration standard
- Dental endorsement conscious sedation registration standard (if relevant)
- Dental English language skills registration standard
- Dental professional indemnity insurance registration standard
- Dental recency of practice registration standard
- Dental scope of practice registration standard
- Dental specialist registration standard (if relevant)

Codes and guidelines

- Dental code of conduct
- Dental guidelines for mandatory notifications
- Dental guidelines on continuing professional development
- Dental guidelines on dental records
- Dental guidelines on infection control
- Dental guidelines for advertising of regulated health services
- Dental guidelines on scope of practice
- Dental guidelines on supervision
- Dental guidelines on conscious sedation Area of Practice Endorsement

Policies

- Dental interim policy – teeth whitening/bleaching

38. Have you completed the Recency of Practice/Return to Practice self assessment questionnaire?

The *Recency of practice/return to practice self assessment questionnaire* can be found on the Board's website at www.dentalboard.gov.au

YES



You **must** attach to this application the *Recency of Practice/Return to Practice self assessment questionnaire*.

NO



You **must** complete and attach to this application the *Recency of Practice/Return to Practice self assessment questionnaire*.

SECTION K: Declaration

Before you sign and date this form: Make sure that you have answered all of the relevant questions correctly, read the statements below and provided the requested supporting documentation **and** the *Recency of practice/Return to practice self assessment questionnaire*. An incomplete form may delay processing and you may be asked to complete a new form. For more information, see the *Information and definitions* section of this form.

I declare that the information provided on this form and the documents provided in support of this application, are true and correct.

Name of applicant

Date

 / /

Signature of applicant

SECTION L: Checklist


Have the following items been attached or arranged, if required?

<i>Additional documentation</i>		Attached
Question 3	Evidence of a change of name	<input type="checkbox"/>
Question 8	A separate sheet with details of the change in the type of dental care you provide	<input type="checkbox"/>
Question 9	A separate sheet with details of the type of practice you intend to return to	<input type="checkbox"/>
Question 10	A separate sheet with details of the work environment you intend to return to	<input type="checkbox"/>
Question 11	A separate sheet with your reason for submitting this form	<input type="checkbox"/>
Question 13	A separate sheet with additional work history details	<input type="checkbox"/>
Question 14	A separate sheet with an explanation of the breaks in your practice history	<input type="checkbox"/>
Question 18	A separate sheet with details of your role, scope of practice and clinical procedures in your last practising role	<input type="checkbox"/>
Question 20	A separate sheet with details of your last role involving direct patient care	<input type="checkbox"/>
Question 21	A separate sheet with details of procedures regularly referred to other practitioners	<input type="checkbox"/>
Question 25	Certified copies of any additional qualifications relevant to the type of dental care you plan to provide	<input type="checkbox"/>
Question 25	A separate sheet with additional course details	<input type="checkbox"/>
Question 26	Certified copies of evidence that indicate completion of a bridging program and a course content/outline	<input type="checkbox"/>
Question 27	A separate sheet with additional qualification details	<input type="checkbox"/>
Question 28	Certified copies of your current or previous registration in dentistry outside of Australia	<input type="checkbox"/>
Question 29	A separate sheet with additional registration details	<input type="checkbox"/>
Question 30	Certified copies of evidence of your participation in professional development activities	<input type="checkbox"/>
Question 30	A separate sheet with additional professional development details	<input type="checkbox"/>
Question 31	Certified copies of evidence of your recent participation in infection control training	<input type="checkbox"/>
Question 32	Certified copies of evidence of your recent participation in CPR training	<input type="checkbox"/>
Question 33	A separate sheet with additional details of your activities related to dentistry	<input type="checkbox"/>
Question 34	A separate sheet with additional details regarding the maintenance of your involvement with the profession	<input type="checkbox"/>
Question 35	A separate sheet with additional details of your non-compliance with registration requirements	<input type="checkbox"/>
Question 36	A separate sheet with additional details of findings made against you	<input type="checkbox"/>
Question 38	Your <i>Recency of practice/return to practice self assessment questionnaire</i>	<input type="checkbox"/>

Please post this form with payment and required attachments to:

AHPRA
GPO Box 9958
IN YOUR CAPITAL CITY (*refer below*)

You may contact AHPRA on
 1300 419 495 or you can lodge an enquiry
 at www.ahpra.gov.au

Sydney NSW 2001 Canberra ACT 2601 Melbourne VIC 3001 Brisbane QLD 4001
 Adelaide SA 5001 Perth WA 6001 Hobart TAS 7001 Darwin NT 0801



Information and definitions

CERTIFYING DOCUMENTS

DO NOT send original documents unless specified.

Copies of documents provided in support of an application, or other purpose required by the National Law, must be certified as true copies of the original documents. Each and every certified document **must**:

- be in English. If original documents are not in English, you must provide a certified copy of the original document and translation in accordance with AHPRA guidelines, which are available at www.ahpra.gov.au/registration/registration-process
- be initialled on every page by the authorised officer. For a list of people authorised to certify documents, visit www.ahpra.gov.au/certify
- be annotated on the last page as appropriate e.g. 'I have sighted the original document and certify this to be a true copy of the original' and signed by the authorised officer, and
- list the name, date of certification, and contact phone number, and position number (if relevant) and have the stamp or seal of the authorised officer (if relevant) applied.

Certified copies will only be accepted in hard copy by mail or in person (not by fax, email, etc). Photocopies of previously certified documents will not be accepted. For more information, AHPRA's guidelines for certifying documents can be found online at www.ahpra.gov.au/certify

CHANGE OF NAME

You must provide evidence of a change of name if you have ever been formally known by another name(s) or any of the documentation you are providing in support of your application is in another name(s).

Evidence must be a certified copy of one of the following documents:

- Standard marriage certificate (ceremonial certificates will not be accepted)
- Deed poll
- Change of name certificate

Faxed, scanned or emailed copies of certified documents will not be accepted.

PRACTICE

Practice means any role, whether remunerated or not, in which you use your skills and knowledge as a health practitioner in your profession. Practice in this context is not restricted to the provision of direct clinical care. It also includes using professional knowledge (working) in a direct non-clinical relationship with clients, working in management, administration, education, research, advisory, regulatory or policy development roles and any other roles that impact on safe, effective delivery of services in the profession.

REGENCY OF PRACTICE

To ensure that you are able to practise competently and safely, you **must** have recent practice in dentistry and in any field of practice (including specialist, endorsement or division of the register), in which you intend to work during the period of registration for which you are applying.

If in the previous five years you have not practised in dentistry or the field of practice in which you intend to work during the period of registration, you will need to satisfy the Board's recency of practice requirements.

For more information, view the full registration standard online at www.dentalboard.gov.au/Registration-Standards