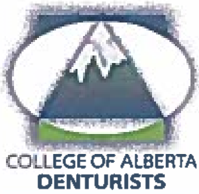

Work Experience Declaration

For application to the College of Alberta Denturists as a Regulated Member

Instructions:

Please Print or Type this form; illegible forms will be returned.

You are required to attach letters of reference regarding work experience to this form, from each indicated location. These letters of reference are to be from either the clinic owner, or a managing representative, and are to verify timelines of work and what work duties were performed by you.If the letters are not provided in English, then you are required to have a letter of translation done by an eligible interpreter, who must certify the translation.

If you have additional locations, please photocopy this page and attach.

Applicant Name: ______________________________

Work Experience Location #1

1. ☐ N/A – **Please sign the Certification/Affirmation and return with your application.**
2. Dates of Employment: ______________________________
3. Clinic Name: ______________________________
4. Address: ______________________________
5. City: ______________________________
6. Province/State: ______________________________
7. Country: ______________________________
8. Are/were you the Clinic Owner:

   ☐ Yes ☐ No- (state clinic owner's name): ______________________________

Work Experience Location #2

9. ☐ N/A – **Please sign the Certification/Affirmation and return with your application.**
10. Dates of Employment: ______________________________
11. Clinic Name: ______________________________
12. Address: ______________________________
13. City: ______________________________
14. Province/State: ______________________________
15. Country: ______________________________
16. Are/were you the Clinic Owner:

    ☐ Yes ☐ No- (state clinic owner's name): ______________________________

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Work Experience Location #3

17. ☐ N/A – **Please sign the Certification/Affirmation and return with your application.**

18. Dates of Employment: ______________________________

19. Clinic Name: ______________________________

20. Address: ______________________________

21. City: ______________________________

22. Province/State: ______________________________

23. Country: ______________________________

24. Are/were you the Clinic Owner:

☐ Yes ☐ No- (state clinic owner's name): ______________________________

Work Experience Location #4

25. ☐ N/A – **Please sign the Certification/Affirmation and return with your application.**

26. Dates of Employment: ______________________________

27. Clinic Name: ______________________________

28. Address: ______________________________

29. City: ______________________________

30. Province/State: ______________________________

31. Country: ______________________________

32. Are/were you the Clinic Owner:

☐ Yes ☐ No- (state clinic owner's name): ______________________________

CERTIFICATION/AFFIRMATION

I hereby certify/affirm that the information contained in this form is accurate and complete to the best of my knowledge, and I understand and agree that the application fee related to this application is a non-refundable fee, and I sign this in the presence of a witness on this

______day of ________, 20____, at ______________________________,

______________________________, ______________________________.

Province/State/District Country

Applicant Name (Print) ______________________________ Witness Name (Print) ______________________________

Applicant Signature ______________________________ Witness Signature ______________________________

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