



APPDHA

Association of Private Practice Dental Hygienists of Alberta

2011 PRIVATE PRACTICE ROSTER MEMBERSHIP APPLICATION

Please complete and print the following form. Membership is \$200.00 per year July1-June 30. Send your completed form, along with a certified cheque made payable to APPDHA to: APPDHA Membership, Suite 101 – 999 Bow Valley Trail, Canmore, AB, T1W 1N4

Year of graduation from accredited program

I have a minimum of 3 years clinical experience Yes_____ No_____

CRDHA Practice Permit #_____ CDHA membership #_____

Liability Insurance Policy # and Company_____

First Name:_____ Last Name:_____

Company Name:_____

Address:_____

City:_____ Postal Code:_____

Geographic Area you service:_____

Phone:_____ Fax:_____

Email:_____

Time Basis of Practice: (*Full-time, Part-time, Limited Hours*)_____

Languages offered:_____ Currently accepting clients: Yes____ No ____

Area of Clinical Concentration: (*In 40 words or less, list your area of clinical concentration such as mobile, storefront, consulting, seniors*)

As an association of fellow dental hygienists in private practice, APPDHA strongly recommends that you:

- comply with APPDHA’s definition of a Private Practitioner in that you are an individual clinician in private practice, are self employed, are the owner/co-owner of the practice, are registered with College of Registered Dental Hygienists of Alberta, and have a minimum of 3 years clinical experience.
- carry self-coverage professional liability insurance a required by CRDHA
- carry commercial liability insurance and any additional liability that may be required
- follow best business practices, including sound accounting, secretarial and marketing plans and procedures, follow IPC Standards, as well as abide by CRDHA advertising rules
- charge appropriate fees for your professional services which reflect your market area and in full use of the unique ID number issued by CDHA
- be in good standing with the CRDHA and CDHA
- No refunds are issued.

I have read and understand these recommendations. The information that I have provided on this form is true.

Signature:_____ Date:_____

Questions? Email: info@mydentalhygienist.ca

Fax: 403-609-9925