Royal College of
Dental Surgeons of Ontario

Ensuring Continued Trust

Application for a Certificate of Authorization for a Health Profession Corporation

6 Crescent Road, Toronto, ON Canada M4W 1T1
T: 416.961.6555 F: 416.961.5814 Toll Free: 800.565.4591 www.rcdso.org

Instructions and Checklist

Application forms for a Certificate of Authorization for a Health Profession Corporation ("Corporation") that are incomplete may be returned.

You are reminded that the $750.00 fee accompanying the application form is non-refundable. The fee may be paid by certified cheque, money order, use of written authorization for payment by Visa, American Express or MasterCard, or by cash. Please note that cash is not recommended.

INSTRUCTIONS

Prior to submitting your application form, please ensure that the following criteria have been met:

1. A Director and/or Officer (must be a dentist and member of the College) authorized to sign on behalf of the Corporation has signed the application form.

2. The same Director that signed the application form has also signed the required Declaration.

3. Each Director and/or Officer (must be a dentist and member of the College) of the Corporation has executed an Undertaking in Form C. Please make as many copies of the form as required.

4. Each Dentist Shareholder (must be a member of the College) of the Corporation has executed an Undertaking in Form D. Please make as many copies of the form as required.

5. In completing the Application Form, if more space was required, you have attached additional pages appropriately labelled.

CHECKLIST

The application for a Certificate of Authorization for a Health Profession Corporation is considered incomplete without the following enclosures:

1. ☐ Signed application form completed by the same Director of the Corporation who signed the Declaration. (See item 3.)

2. ☐ Fee in the amount of $750.00 payable to the Royal College of Dental Surgeons of Ontario

3. ☐ Declaration signed by a Director (must be a member of the College) of the Corporation **not more than 15 days** before the application is submitted to the College.

4. ☐ Corporate Profile Report of the Corporation issued by the Ministry of Government Services Ontario* **not more than 30 days** before the application is received by the College which indicates that the corporation is active.

5. ☐ Copy of the Articles of Incorporation of the Corporation

6. ☐ Copy of every Certificate of the Corporation (must be issued by the Ministry of Government Services Ontario*) that has been endorsed under the Business Corporations Act (Ontario) as of the day the application is submitted.

7. ☐ Undertaking in Form C to be completed by each Director and/or Officer (must be a dentist and member of the College) of the Corporation.

8. ☐ Undertaking in Form D to be completed by each Dentist Shareholder (must be a member of the College) of the Corporation (excluding Director(s) who have completed Form C).

* May also be issued by a service provider which is under contract with the Ministry of Government Services Ontario.

05/16_4261

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PART A

Application for a Certificate of Authorization for a Health Profession Corporation

1. NAME OF HEALTH PROFESSION CORPORATION

____

____

ONTARIO CORPORATION NO. ISSUED BY MINISTRY

____

Note: The name of the Corporation must comply with the requirements of s.1 of Ontario Regulation 39/02 of the Regulated Health Professions Act, 1991 (Ontario).

2. BUSINESS ADDRESS OF HEALTH PROFESSION CORPORATION (If using home address this information is available to the public and will be published.)

STREET: SUITE:

CITY: PROVINCE: POSTAL CODE:

TEL: FAX: E-MAIL (optional):

3. NAME(S) OF VOTING DENTIST SHAREHOLDER(S) AS OF THE DAY THE APPLICATION IS SUBMITTED *(must be a member of the College)* AND HIS/HER REGISTERED PRACTICE ADDRESS, TELEPHONE NUMBER AND REGISTRATION NUMBER WITH THE COLLEGE AS OF THAT DAY.

COLLEGE REGISTRATION #:		
LAST NAME:	GIVEN NAMES (underline one commonly used):	
PRACTICE ADDRESS (STREET):		SUITE:
CITY:	PROVINCE:	POSTAL CODE:
TEL:	FAX:	E-MAIL:

COLLEGE REGISTRATION #:		
LAST NAME:	GIVEN NAMES (underline one commonly used):	
PRACTICE ADDRESS (STREET):		SUITE:
CITY:	PROVINCE:	POSTAL CODE:
TEL:	FAX:	E-MAIL:

COLLEGE REGISTRATION #:		
LAST NAME:	GIVEN NAMES (underline one commonly used):	
PRACTICE ADDRESS (STREET):		SUITE:
CITY:	PROVINCE:	POSTAL CODE:
TEL:	FAX:	E-MAIL:

COLLEGE REGISTRATION #:		
LAST NAME:	GIVEN NAMES (underline one commonly used):	
PRACTICE ADDRESS (STREET):		SUITE:
CITY:	PROVINCE:	POSTAL CODE:
TEL:	FAX:	E-MAIL:

(Attach additional pages appropriately labelled, if necessary.)

FOR OFFICE USE ONLY Date Received: ____________ Certificate No.: ____________ Date Issued: ____________ Date Denied: ____________

4. NAME(S) OF DIRECTOR(S) / OFFICER(S) AS OF THE DAY THE APPLICATION WAS SUBMITTED *(must be a dentist and member of the College)*

Note: All directors and officers must also be shareholders of the corporation who are members of the Royal College of Dental Surgeons of Ontario.

Please check the appropriate box if you are a director.

If you are also an officer, please check that box and indicate the title of your office.

COLLEGE REGISTRATION #	FULL NAME	DIRECTOR	OFFICER	PROVIDE TITLE OF OFFICE
		☐	☐	
		☐	☐	
		☐	☐	
		☐	☐	
		☐	☐	
		☐	☐	

(Attach additional pages appropriately labelled, if necessary.)

5. NAME(S) OF INDIVIDUAL(S) *(must be a dentist and member of the College)* THAT WILL PRACTISE ON BEHALF OF THE CORPORATION INCLUDING ALL SHAREHOLDERS, PARTNERS, ASSOCIATES AND DENTIST EMPLOYEES OF THE CORPORATION AS OF THE DAY THE APPLICATION WAS SUBMITTED.

COLLEGE REGISTRATION #	FULL NAME

6. THE CORPORATION INTENDS TO PRACTISE AND/OR CARRY ON BUSINESS IN THE FOLLOWING LOCATION(S):

Note: Do not use home address in this section.

STREET:		SUITE:
CITY:	POSTAL CODE:	BUSINESS PHONE:

STREET:		SUITE:
CITY:	POSTAL CODE:	BUSINESS PHONE:

STREET:		SUITE:
CITY:	POSTAL CODE:	BUSINESS PHONE:

STREET:		SUITE:
CITY:	POSTAL CODE:	BUSINESS PHONE:

STREET:		SUITE:
CITY:	POSTAL CODE:	BUSINESS PHONE:

STREET:		SUITE:
CITY:	POSTAL CODE:	BUSINESS PHONE:

7. PLEASE PROVIDE A BRIEF DESCRIPTION OF THE PROFESSIONAL ACTIVITIES TO BE CARRIED OUT BY THE CORPORATION.

Note: The Corporation cannot carry on, and cannot plan to carry on, any business that is not the practice of dentistry or activities related to or ancillary to the practice of dentistry (Ontario Regulation 39/02, subparagraph 6(ii) of subsection 2(1).)

I confirm that the information contained in this Application for a Certificate of Authorization for a Health Profession Corporation is complete and accurate.

Signature of Director authorized to sign on behalf of the Corporation
(must be a dentist and member of the College)

Date

Please print name.

College Registration Number

FORM B

Declaration of a Dentist

I, _____ , a director of
[Insert Full Name of Dentist]

_____ ,
[Insert Full Name of Health Profession Corporation (Corporation)]

do hereby solemnly certify that the following statements are true:

1. I am a member of the College holding Certificate of Registration No. _____ .

2. I am a director of the Corporation and have the authority to apply for a Certificate of Authorization.

3. The Corporation is in compliance with section 3.2 of the Business Corporations Act (Ontario) including the regulations made under that Act applicable to a dentistry professional corporation, as of the date this Declaration is signed.

4. The Corporation is in compliance with the Regulated Health Professions Act, 1991 including the regulations made under that Act applicable to a dentistry professional corporation, and in particular, subparagraph 2.2 of subsection 1(1) of Ontario Regulation 39/02[1] as of the date this Declaration is signed.

5. The Corporation does not plan to carry on and will not carry on any business that is not the practice of dentistry or an activity related to or ancillary to the practice of that profession.

6. There has been no change in the status of the Corporation since the date of the Corporate Profile Report submitted to the College as part of the Application for a Certificate of Authorization.

7. The information contained in the Application for a Certificate of Authorization that accompanies this Declaration is true, complete and accurate as of the day this Declaration is signed.

_____ (/ /)
Signature of Director (must be a dentist and member of the College) Date DD MM YYYY

_____
Name of Director (signatory) (please print)

[1] **NOTE: Subparagraph 2.2 of subsection 1(1) of Ontario Regulation 39/02 requires that:**

- **each issued and outstanding voting share of the corporation be legally and beneficially owned, directly or indirectly, by a member of the College; and**
- **each issued and outstanding non-voting share of the corporation be owned in one of the following ways:**

  i. legally and beneficially, directly or indirectly, by a member of the College;
  ii. legally and beneficially, directly or indirectly, by a family member of a voting dentist shareholder; or
  iii. legally by one or more individuals, as trustees, in trust for one or more children of a voting dentist shareholder who are minors, as beneficiaries.

FORM C
TO BE COMPLETED BY EACH DIRECTOR

Undertaking

Each Director of the Health Profession Corporation to execute a separate Undertaking.

I,_____, a member of the Royal College of Dental Surgeons
Name of Director

of Ontario (College) and a director and a shareholder of _____

_____
Name of Corporation (Corporation)

UNDERTAKE TO THE COLLEGE AS FOLLOWS:

1. I accept professional responsibility for any act or omission of the Corporation that would be professional misconduct if such act or omission had been committed or omitted by a member of the College.

2. I will ensure that the Corporation does not do or cause to be done or omit or cause to be omitted anything that would be professional misconduct if done or omitted to be done by a member of the College.

3. I will ensure that the Corporation does not engage in the practice of dentistry or any activity related or ancillary to the practice of that profession unless it maintains a valid Certificate of Authorization issued by the College.

4. I will ensure that the Corporation does not practise under any name other than the name of the Corporation, a practice name previously approved by the College for use by a dentist shareholder of the Corporation or a name permitted by Regulation.

5. I will ensure that the Corporation complies with the Regulated Health Professions Act, 1991, the Dentistry Act, 1991, the regulations made under those Acts, and the by-laws of the College.

6. I will ensure that the College is notified immediately of any change in shareholders of the Corporation and that any future dentist shareholder of the Corporation execute and file with the College, within ten days of becoming a shareholder of the Corporation, an Undertaking in a form approved by the College.

7. I will ensure that the College is notified of any changes to practice locations of the Corporation as soon as they occur.

8. I acknowledge that a breach of this Undertaking may result in referral of specified allegations of professional misconduct against me to the Discipline Committee arising out of my failure to abide by any of the terms of this Undertaking.

9. I acknowledge having been advised to obtain independent legal advice prior to signing this Undertaking.

_____ _____
Signature of Director (must be a dentist and member of the College) Signature of Witness

_____ _____
Name of Director (please print) Name of Witness (please print)

(/ /)
Date DD MM YYYY

FORM D
TO BE COMPLETED BY EACH DENTIST SHAREHOLDER
(must be a member of the College)

Undertaking

Each Shareholder of the Health Profession Corporation to execute a separate Undertaking.

I, _____, a member of the Royal College of Dental Surgeons
Name of Shareholder

of Ontario (College) and a shareholder of _____

_____
Name of Corporation (Corporation)

UNDERTAKE TO THE COLLEGE AS FOLLOWS:

1. I accept professional responsibility for any act or omission of the Corporation that would be professional misconduct if such act or omission had been committed or omitted by a member of the College.

2. I will ensure that the Corporation does not do or cause to be done or omit or cause to be omitted anything that would be professional misconduct if done or omitted to be done by a member of the College.

3. I will ensure that the College is notified within ten (10) days if I cease to be a shareholder of the Corporation.

4. I acknowledge that a breach of this Undertaking may result in referral of specified allegations of professional misconduct against me to the Discipline Committee arising out of my failure to abide by any of the terms of this Undertaking.

5. I acknowledge having been advised to obtain independent legal advice prior to signing this Undertaking.

_____ _____
Signature of Dentist Shareholder (must be a member of the College) Signature of Witness

_____ _____
Name of Shareholder (please print) Name of Witness (please print)

(/ /)
Date DD MM YYYY

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Health Profession Corporation Fee – $750.00 Payable to RCDSO

PLEASE PRINT

NAME OF PROPOSED HEALTH PROFESSION CORPORATION

NAME OF DIRECTOR AUTHORIZED TO SIGN ON BEHALF OF CORPORATION

SURNAME: GIVEN NAMES:

ADDRESS

STREET: CITY/TOWN:

POSTAL CODE: TELEPHONE:

PLEASE COMPLETE THIS SECTION FOR METHOD OF PAYMENT

You may elect to pay your fees by any one of the following methods:

A) CERTIFIED Cheque or Money Order.

B) Credit Card. If you pay by credit card, the form below must be completed. While we are pleased that we are able to accept payment by credit card, we are unable to do so by telephone.

☐ CERTIFIED CHEQUE ☐ MONEY ORDER ☐ VISA ☐ MASTERCARD ☐ AMERICAN EXPRESS

CREDIT CARD #: EXPIRY DATE:

SIGNATURE:

FOR OFFICE USE ONLY - AUTHORIZATION APPROVED - COMMENTS

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