

DCNZ



**Dental Council**  
of New Zealand

Te Kaunihera Tiaki  
Niho o Aotearoa

## Form NE002:

# Application for enrolment in the New Zealand Dental Technician Registration Examination

Attach 3 passport  
photos here

### Notes:

- Please print all answers clearly.
- Applications will not be processed unless completed in full and accompanied by the required documents and fees
- This application form is to be used by candidates who have previously enrolled for the Dental Technician Registration Process or have been assessed and approved by an Australian Dental Technician Board to enter the Examination process
- If you have not previously enrolled in an examination administered by the Dental Council or have not previously applied for registration please use form NE001.

### Dental Technician Examination Date *(refer to website)*

Requested Examination date: \_\_\_\_\_

### Name

Given Names

Family Name

Other Names

If names differ from those on your dental qualification, please tick box to show reason, and attach evidence

Marriage

Deed Poll

Common Use

Other (explain)

### Identification

Birthplace (including country)

Date of Birth (day, month, year)

Gender (please tick)

Male

Female

Please provide certified copies from the relevant identification pages of your passport

### Contact Details

Postal Address:

Alternative contact address

Phone

Phone

Fax

Fax

Email

Email

**Previous registration applications**

Have you previously applied for registration with the Dental Council or the Dental Technicians Board or to sit any New Zealand dental registration examinations?

(please tick)  Yes  No

If yes, please give details of the date of application and registration and/or candidate number if applicable:

**Australian Candidates (only)**

What Registration Board in Australia has approved your entry to the Dental Technician examination?

I have attached an original letter from the Dental Technician Board or equivalent approving my eligibility to enter the examination process:

(please tick)  Yes

**Verification of Identity**

I, \_\_\_\_\_ (Name in full)  
\_\_\_\_\_ (Witness)

of \_\_\_\_\_ (Address)  
\_\_\_\_\_

certify that the 3 attached recent colour passport-size photographs are a true likeness of

\_\_\_\_\_ (Name in full)  
(Applicant)

signed \_\_\_\_\_ Date \_\_\_\_\_  
(Witness)

**NOTE: The witness must not be another examination candidate, or relative of the candidate**

**Payment**

Cheque (\*)

Credit card (Visa or Mastercard only - provide details below):

Type of Card:

Name on Card:

Expiry date:

Card No:

Amount NZ\$:

Signature:

(\*) cheques must be payable to the Dental Council of New Zealand and be drawn on a New Zealand trading bank

Please return this completed form, with the correct fee, to:

The Examinations Officer  
The Dental Council of New Zealand  
PO Box 10-448  
Wellington  
New Zealand

Phone (04) 499 4820  
Fax (04) 499 1668  
Email [inquiries@dcnz.org.nz](mailto:inquiries@dcnz.org.nz)

REMEMBER TO KEEP COPIES OF YOUR APPLICATION FORM AND ALL ACCOMPANYING DOCUMENTS