



Application for Retention Bonus Program

Please indicate which rural area or clinic you are planning on serving:

APPLICANT INFORMATION

Surname: _____	Given Name: _____	Initial: _____
Current Mailing Address:	Permanent Mailing Address (if different):	
Home Province: _____		
Telephone: _____	Email: _____	

EDUCATION AND EMPLOYMENT

Dental School Attended: _____	Year of Graduation: _____
Do you hold a current license to practice Dentistry in the Province of NL <input type="checkbox"/> Yes <input type="checkbox"/> No	
In the past 12 months did you provide:	
<input type="checkbox"/> 100-450 hours of service in an underserved (Tier 3) community	
<input type="checkbox"/> 450-600 hours of service in an underserved (Tier 3) community	
<input type="checkbox"/> more than 600 hours of service in an underserved (Tier 3) community	
What was the community name, or the name of the clinic? _____	

PREVIOUS FUNDING

Have you previously received funding under the Dental Bursary Program or for any other program offered by the Department of Health and Community Services?

Yes No If Yes, please provide details and amounts: _____

SIGNATURE

Please include with application:

- Proof of licensure with the Newfoundland and Labrador Dental Board*
- Cover letter which highlights your suitability for the Retention Bonus Program*
- Current resume outlining your education and career history*
- Three (3) letters of reference; at least one from a previous employer or academic reference, and one from the owner or management of the clinic in which you plan on practicing.*

Personal information on this form is being collected the purpose of evaluating retention bonus applications. This information is being collected under the authority of section 61(c) of the Access to Information and Protection of Privacy Act, 2015. By signing this form you have consented to the collection and sharing of this information between the Medical Services Division of the Department of Health and Community Services and the Newfoundland and Labrador Dental Association for the purpose of evaluating dental bursaries. Should you have any questions about the collection, use or disclosure of your personal information, please contact the Dental Consultant at the email address below.

Verification of identity and current address is required (see policy for additional details).

I certify that all information given on this application is complete and true to the best of my knowledge.

Applicant Signature: _____ Date: _____

(You may sign digitally; or print, sign, and scan this form)

Please email all required documentation to:

Dr. Michelle Zwicker

Dental Consultant

Medical Services Division

Department of Health and Community Services

Government of Newfoundland and Labrador

(709) 758-1503

MichelleZwicker@gov.nl.ca