It’s Renewal Time
2012 Annual Certificate of Registration Renewal
Our Winter 2011 Issue

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President's Message

The mission of the College of Dental Hygienists of Ontario is to regulate the practice of dental hygiene in the interest of the overall health and safety of the public of Ontario.

La mission de l'Ordre des hygiénistes dentaires de l'Ontario consiste à réglementer l'exercice de la profession d'hygiène dentaire de sorte à favoriser l'état de santé global et la sécurité du public ontarien.

Council

Carol Barr Overholt – District 3 (RDH)
Cathleen Blair – District 5 (RDH)
Heather Blondin – District 7 (RDH)
Michele Carrick – District 1 (RDH)
Linda Jamieson – Academic (RDH)
Caroline Lotz – Academic (RDH)
Inga McNamara – District 2 (RDH)
Janet Munn – District 6 (RDH)
Lucy Pavo – District 4 (RDH)
Shirley Silverman – District 4 (RDH)
Ilgia St. Onge – District 8 (RDH)

Michael Connor – Barrie (PM)
Eliot Feldman – Toronto (PM)
Julia Johnson – Orillia (PM)
Shori Katyal – Toronto (PM)
Samuel Laldin – Kingston (PM)
Derrick McLennon – Scarborough (PM)
Tote J. Quizan – Scarborough (PM)
Salam Rifa – Mississauga (PM)
Charles F. M. Ross – London (PM)
Ben Shayan – Richmond Hill (PM)
Anne Venton – Toronto (PM)

RDH - Registered Dental Hygienist
PM - Public Member

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Romaine Hesketh (RDH)
Shelli Jefts (RDH)
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Gail Marion (RDH)
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CDHO News

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The College of Dental Hygienists of Ontario has a tradition of having the President provide some opening remarks at our Council meetings. Often these remarks are transformed into the President’s message that is published in the next edition of Milestones. The President’s message provides a connection between the registrant and the Council of elected (professional) and appointed (public) members. Deciding what to talk about is always challenging. Should the message focus on a key trend or event? Is it an opportunity to set the stage for the Council meeting? Should the message announce a future direction for the College? While all of these are important reasons for a President’s message, I have chosen to use this opportunity to inform registrants of important initiatives undertaken by Council and the CDHO’s Administration.

On October 27, the day prior to our Council meeting, Council and Administrative staff participated in a workshop that reviewed our 2011 activities. This is part of our annual planning process where we determine if we have met the priorities we set at the beginning of the year. I am pleased to report that we have advanced all of these priorities and more. In fact, the day was so full of information that we were hard pressed to cover all of our accomplishments in the time we had.

We began the day with an inspiring workshop on Managing Change, conducted by Robert Harris. This workshop provided Council and Administration with valuable tools that we could use to manage the many changes that affect the CDHO. As one Council member said, ‘the only constant is change’, and so it is important for Council and Administration to develop the capacity to respond to change effectively and efficiently.

Following our session on Managing Change we summarized the main activities of the organization for the past year and identified priorities for next year. Let me provide the highlights.

Our Patient Education Plan continues to roll out; this year we introduced a number of new print messages and voice messages that inform the public and other health care professionals of the important role dental hygienists play in oral health and health care.

We saw the successful launch of a new, more user-friendly website and our Setting the Record Straight program. We added eight new advisories to the Knowledge Network and updated 16 more. We also collaborated with the College of Respiratory Therapists of Ontario to draft best practice guidelines for Oral Care for Ventilated Patients. I look forward to seeing how the results of this project will be used to support improved health care.

The national competencies and our new standards of practice are being incorporated into the curricula of dental hygiene programs in Ontario. Dental hygiene students who began their programs in Fall 2011 will graduate fully prepared to meet the CDHO’s new Standards of Practice.

The CDHO also demonstrated its commitment to critical reflection of our programs and services. This is evidenced by an impressive list of evaluations we have completed or have in process [see Table 1]. Each evaluation provides valuable information that supports continuous quality improvement initiatives within the organization. We are doing a great job!

Our success as an organization and our ability to fulfill our mandate to ‘effectively regulate the profession of dental hygiene in Ontario’ is made possible because Council is committed to good governance and fully engaged in the planning and evaluation process. Our successes can also be attributed to the tremendous work of Administrative staff who consistently strive for excellence.

.../continued on page 5
The issue of respect has once again become front and centre on my radar. Perhaps “respect” has become an outmoded word to some, or perhaps it just isn’t in their vocabulary. There are a number of ways in which dental hygienists in Ontario can serve the public interest, be proud of their profession and honour the spirit of the Regulated Health Professions Act (RHPA), 1991 and the Dental Health Act (DHA), 1991.

**Language**
When speaking about the profession, the legal name is “dental hygienist” not just “hygienist”. When speaking about colleagues, they are not “the girls” as we definitely do have male registrants, and the term “girl” is demeaning when referencing a grown woman who happens to be a professional in her own right. The term “check-up” is often misunderstood by the public; “oral health assessment” is more akin to the nature of the procedure performed by a dental hygienist.

**Choice of Practice Setting**
Due to the legislative changes in 2007, the public has the opportunity to choose preventive oral health care when, where and from whom they choose. This means that to meet the public’s expectations, dental hygienists also have the choice of practising in a variety of formats. Not every choice appeals to every registrant. However, it behooves registrants to respect the choice of their colleagues, whether it is in practice with another health care provider, on their own, in public health, in academia, in research, in administration or any combination of the aforementioned.

To denigrate another person’s choice takes away from the public’s right to choose what works for them.

**Regulations, Bylaws, etc.**
Rules and regulations are a necessary part of a civilized society – without them there would be anarchy. Dental hygienists in Ontario have the privilege of being self-regulated; something our colleagues in most of the USA can only dream about. The regulations are written and enforced for the protection of the public – not to make the professional “jump through hoops” – but to make the practice of the profession as safe as possible for the public. Respect for the regulations, means that registrants take the responsibility of abiding by them, and correcting mistakes when required.

**Standards of Practice**
Every profession has standards and guidelines, though not all are published for the public to view. Standards are not theoretical fiction that can be chosen or discarded at will to satisfy an employer or to make the registrant’s life easier! Standards are developed to let the profession know what is expected of them, to translate competencies, to assist in the safe provision of care and as a benchmark for comparison if there is a concern about the registrant’s practice.

**In the Public Interest**
The term “in the public interest” is not defined in the RHPA, 1991. However, those Colleges regulated under the RHPA, 1991 are charged with regulating the profession “in the public interest”.

Fran Richardson, RDH, BScD, MEd, MTS
Registrar
“We begin to die the day we remain silent about things that matter.”
- Martin Luther King

Some Colleges define the term very narrowly, while others define it quite broadly. Some Colleges have stated that promoting access to health care is not within their mandate, while other Colleges have taken the stance that access to health care is one of the roles of their particular College.

**The Role of the College**

The CDHO is not an association of like-minded individuals within a specified group; it is a regulatory authority charged with a specific mandate. While there may be many registrants, and sometimes their employers who do not agree with how the College carries out its business, it is the role of the College to regulate the practice of dental hygiene in Ontario and it is the role of the College to ensure that registrants are practising to the standards set by the CDHO. For many years, dental hygienists all over Canada fought for self-regulation stating that they were capable of governing themselves in the public interest and they persevered through the growing pains of establishing provincial colleges, including our College in Ontario. Respect for the process means abiding by the rules, acting as a professional and always, always, putting the client first before self!

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**President’s Message continued from page 3**

Even as we celebrate our accomplishments of 2011, we are also acutely aware that 2012 will be a year of incredible change. We will continue to work on several important projects. Our Practice Advisors and the Quality Assurance Committee will be adapting their processes so registrants will receive support as they adapt their practices to meet the new Standards of Practice. Administration will continue to work on improving the organization’s infrastructure to increase efficiency and effectiveness of our internal processes.

<table>
<thead>
<tr>
<th>Evaluations Completed 2011</th>
<th>Evaluations Planned 2012</th>
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<tr>
<td>• Setting the Record Straight – (preliminary report 2011)</td>
<td>• Setting the Record Straight</td>
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<tr>
<td>• Information Technology Audit</td>
<td>• Investigation Process – Inquiries, Complaints and Reports Committee</td>
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<tr>
<td>• Office of the Fairness Commissioner Audit</td>
<td>• Jurisprudence on-line module</td>
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<tr>
<td>• Council Performance – 3 times per year related to Council meetings</td>
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In 2012, the CDHO will also experience a change in leadership. Our Registrar, Fran Richardson will be retiring in April. Fran has been the face of the CDHO for 17 years and her commitment to the CDHO and the profession has been unwavering. I know that Fran will continue to serve us well even as we search for a new Registrar. Council will be responsible for selecting a new registrar. Changes in leadership are never easy and often associated with anxiety and fear of the unknown. However, I am confident that the CDHO will be able to manage this transition.

According to our bylaws, the maximum term for a president is three years and this marks my third year. This means that this is my final message as President. I want to take this opportunity to thank Council for their confidence in me by allowing me the opportunity to serve as President. This experience has certainly caused me to grow personally and professionally, and given me a unique insight into the regulation of my profession.

The CDHO’s success is your success, as it reinforces the public’s trust in self-regulation and the dental hygiene profession.
The year 2010 saw the successful launch of a more user-friendly website and the CDHO’s *Setting the Record Straight* program. She reported that the national competencies and the new CDHO *Standards of Practice* were being incorporated into the curricula of dental hygiene programs in Ontario.

Ms. Jamieson highlighted some of the major changes which will take place in 2012, one of which would be a change in leadership as Fran Richardson, Registrar, will be retiring in April 2012.

**Executive Committee**

Ms. Jamieson presented the Executive Report. Council approved at first reading the policy put forward by the Committee that outlined what would be considered a conflict of interest if Council members, Quality Assurance Assessors or Clinical Competency Evaluators were to provide educational and/or mentoring activities to registrants. Council Meeting dates were confirmed for 2012 as January 27, June 01 and November 02. The proposed budget for 2012 was accepted as presented.

**Registration Committee**

Ms. Ilga St. Onge provided an update on the activities of the Registration Committee. She presented a draft policy for Council’s consideration respecting guidelines for restorative dental hygiene. It was agreed that comments made by Council members and other stakeholders would be considered by the Committee prior to presenting a further draft policy for approval.

**Discipline Committee**

The Chair of the Discipline Committee, Ms. Shirley Silverman, reported that there had been one referral to the Discipline Committee since the last Council meeting. However, prior to a discipline hearing date being set in this matter, the registrant signed an Undertaking agreeing to resign from the College and never to re-apply for registration as a dental hygienist with the College. Therefore, a Panel of the Discipline Committee agreed to adjourn the disciplinary proceedings against her indefinitely.

**Inquiries, Complaints and Reports Committee**

Ms. Inga McNamara, Chair of the Inquiries, Complaints and Reports Committee, informed Council that 25 investigations had been completed since the last Council meeting and that there were 35 investigations ongoing.

**Patient Relations Committee**

Ms. Lucy Pavao presented the Patient Relations Committee report, including a mid-term evaluation of the *Setting the Record Straight* presentations, which have been very well received by registrants.

The results of a public affairs survey conducted to obtain information about how the public perceives dental hygienists and how aware they were of what the dental hygienist does was presented to Council, by Graham Loughton, Vice-President, Ipsos Reid.
Quality Assurance Committee
Ms. Michele Carrick reported on behalf of the Quality Assurance Committee. The report provided information on the number of registrants who had been selected in 2010, how many had met the assessment guidelines, and how many were still in process.

Administrative Report
Evelyn Waters, Deputy Registrar, provided an update on Administrative issues. She noted that the number of registrants continues to increase, with 11,250 holding a general certificate of registration, 541 a specialty certificate and 707 an inactive certificate for a total of 12,588 registrants. Ms. Waters informed Council that elections for five Council positions would be held on November 16 and 23. She further advised that 2011 would be the last year that the CDHO would mail out renewal notices. Next year, registrants will be notified of their obligation to renew by email.

Guest Speaker
Jennifer Harrison, RRT, Professional Practice Advisor at the College of Respiratory Therapists of Ontario (CRTO), provided an excellent presentation on the success of the collaborative project between CRTO and CDHO in drafting best practice guidelines for Oral Care for Ventilated Patients.

Next Council Meeting: December 16, 2011 and January 27, 2012
To attend, please call Jane Cain at 416-961-6234 x 226 or 1-800-268-2346, or email jcain@cdho.org. Seating is limited.

Have you visited the Knowledge Network lately?

New Advisories: As of June 2011
- Cerebral Palsy
- Gastrointestinal Tract Tumours

Updated Advisories
- Amyotrophic Lateral Sclerosis
- Multiple Sclerosis
- Parkinson’s Disease
- Stroke

Find the clinical information you need at: www.cdho.org/QAKnowledgeNetwork.htm
Clarification on Direct Billing

The summer 2011 edition of Milestones contained an article entitled “Direct Billing for Dental Hygiene Services” and generated some questions. Registrants who bill third-party payers directly may continue to use their UNI as supplied by the Canadian Dental Hygienists Association. As well, the CDHO requests that registrants use their CDHO registration number so that the College can identify who provided the service, that the dental hygienist is currently registered and can follow up with the appropriate individual should a member of the public have a concern.

Full Periodontal Assessments

How often do I need to complete a full periodontal assessment? We have received calls from registrants asking for clarification on this issue. As stated in the Milestones March 2011 issue (page 16):

The interval between full periodontal assessments (including pocket depths, recession, furcation involvement, mobilities, etc.) should be established for each client on an individual basis. You must be able to support your choice of treatment plan interventions based on the assessment data you have collected.
Elder Abuse: What every registrant should know

Dental hygienists in Ontario are familiar with the requirements for the reporting of suspected child abuse under the *Ontario Child & Family Services Act, 1991*. However, the issue of reporting possible elder abuse is much more complicated. Elder abuse can take many forms: physical; emotional; financial; sexual; and neglect. Unfortunately, there are no definitive statistics on the extent of elder abuse in North America, as many professionals in this field believe that elder abuse is under reported. Dental hygienists are in a unique position to assist in the identification of possible elder abuse due to the fact people often visit their dental hygienist more often and on a regular basis than they do many other health care professionals.

There is an excellent article1 in the May 2011 edition of the *Canadian Journal of Dental Hygiene* on this topic. The author cites a number of resources and delineates the challenges inherent in tackling the problem. In addition, the Canadian Dental Hygienists Association (www.cdha.ca) provides a web-based course, at no charge to the participant, on Elder Abuse. Webinars are also available at this site.


If a dental hygienist suspects that a senior may be the victim of any form of abuse, it is important to speak directly to the individual in a private place, ask if anything is wrong and if the dental hygienist may help. If the individual agrees, then the dental hygienist can refer that person to the appropriate agency in their community, the police if the danger is imminent, or to one of the government contacts noted above.

Amendments to PIPEDA

On September 29, 2011, the Government of Canada reintroduced enhancements to private sector privacy legislation in a bill seeking to amend the *Personal Information Protection and Electronic Documents Act* (PIPEDA). The bill, entitled the *Safeguarding Canadians’ Personal Information Act*, implements the Government Response to the Fourth Report of the Standing Committee on Access to Information, Privacy and Ethics: Statutory Review of PIPEDA. The Government Response addresses each of the 25 recommendations contained in the Committee’s report and committees to amending the Act in agreement with many of the Committee’s recommendations.

Further information, including the associated news release, bill summary and background information, is available at Industry Canada’s website Reintroduction of amendments to the *Personal Information Protection and Electronic Documents Act*.


Renew...

*Online and on time!*

- Renew your registration at www.cdho.org
- Simple, fast and always secure
- The deadline for renewal is January 1, 2012.

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The College continues in its efforts to reduce the amount of paper mailed out. You will notice that you have not received a printed copy of the renewal form. Instead, you are directed to the automated renewal process on our website, which is secure, fast and convenient. Next year, renewal notices will be sent by e-mail only, unless you have indicated a preference to receive it by regular mail.

Fees for 2012 registration are:

<table>
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<th>General or Specialty:</th>
<th>Inactive:</th>
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We are pleased to confirm that, once again, there is no increase in fees. Automating tasks, like the renewal process, helps us to keep costs down.

You can renew online in four easy steps:

1. Log on to our web site at www.cdho.org.

2. Your login ID is your registration number:
   a. If you have changed your password via the online “Address Change”, then your password is what you have chosen.
   b. If you have forgotten your password, the system will e-mail it to you at the e-mail address that the CDHO has on file for you. Just follow the instructions to have your password sent to you by e-mail.
   c. If you have forgotten your password and the College does not have an e-mail address on file for you, contact the CDHO at 416-961-6234.
   d. If you have not changed your password, then your password is the initial password which is your date of birth. Enter it in the format “YYYYMMDD”. For example: if your birthday is August 1, 1962 you will enter 19620801.
   e. **You must change the initial password.** After you log in with your initial password (your birth date), you will be prompted to change it before continuing.

3. Complete the information sections.

4. Payment options:
   a. Online by credit card – VISA or MasterCard only.
   b. By mail or phone – After you complete the information section, you can choose the option of printing an invoice and mailing it to our office with a cheque/money order OR the option of filling in your credit card details, which can be mailed or faxed to the CDHO. You may also call us with your credit card details if that is your preference. However, you will be required to provide your invoice number prior to your information being taken over the phone.

NOTE: Your registration is not renewed until payment has been received. *Your 2012 registration certificate or receipt will no longer be mailed out.*

However, you can view / print / re-print the receipt for your records from the “Address Change” section of the CDHO website. This receipt will be proof of your 2012 status. You can also go to the CDHO website to “Find a dental hygienist” to confirm your status for 2012.
Please note: Our office will be closed from December 26–30, 2011 and will re-open on January 2, 2012. Online Renewal will be available 24/7.

Has your e-mail or mailing address changed?
Please make sure your e-mail and mailing address is correct prior to renewing online. To view and/or correct your addresses that are on file with the CDHO, go to the “Address change” on the CDHO website. Alternatively, you can call, mail, fax or e-mail info@cdho.org with your change of address.

Preferred method of communication?
When you renew for 2012, you are required to indicate on the renewal form, whether you would prefer to receive communications from the CDHO—including the magazine Milestones—by email or regular mail. For future communications, you will only be contacted via your preferred method.

Has your name changed?
Documentation supporting your name change (e.g. copy of marriage certificate) must be submitted to the CDHO prior to you renewing online. Please note that the document is not required to be notarized. This can be forwarded by mail, fax or as an email attachment to info@cdho.org. You should allow 24 hours for processing before returning to the Web Renewal.

Are you changing your category of registration?
If you are changing your current category of Registration from Inactive to a General / Specialty Registration and have practised dental hygiene within the last three years in Ontario, you can renew online. If you have not practised within the last three years in Ontario OR you have practised in another jurisdiction, you cannot renew online. Please contact the College by emailing tmacartney@cdho.org.

You can change your status from a General / Specialty registration to an Inactive registration online by clicking on the ‘Renew as Inactive’ checkbox. If you have been suspended or your registration has been revoked, contact the College by e-mailing tmacartney@cdho.org to reinstate your registration.

Are you resigning or not renewing?
Are you moving to another province or jurisdiction outside Ontario and are not planning on renewing your registration? This can be done online. Just go to “Resigning / Not Renewing”. Alternatively, you can advise the CDHO by mail, e-mail or fax.

Please note that resignations will be effective January 1, 2012.

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<tr>
<th>LATE PAYMENT FEES</th>
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<td>Late Payment: $100</td>
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Renew early to avoid the late payment fee. Your renewal is due on or before January 1, 2012. A late penalty fee of $100 will be imposed after that date. An administrative fee of $25 will be charged for cheques returned as insufficient funds.

Suspension for non-payment of fees
If you do not renew, or do not advise the CDHO that you wish to resign on or before January 1, 2012, your registration will be suspended for non-payment of fees. You will be given 30 days’ notice of the CDHO’s intention to suspend your registration. You cannot practice dental hygiene once your registration has been suspended.

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 Setting the Record Straight – A Great Success

By Robert Farinaccia, RDH, BSc

The CDHO Council targeted 2011 as a year for increased communication with both the public and registrants.

This year I have had the pleasure, along with my colleague and fellow practice advisor Jane Keir, to travel around Ontario to 13 different cities and present the CDHO’s Setting the Record Straight to dental hygienists and dental hygiene students. This initiative was approved by the CDHO Council in 2010 after recognizing that there are many myths and misconceptions circulating in the dental hygiene community that needed clarification. The content for this presentation stemmed from the many practice advice calls we received at the College. These presentations also provided an opportunity for registrants to meet and greet the practice advisors and ask questions about the dental hygiene scope of practice or questions about the College’s policies, procedures and regulations.

For the first time, the CDHO used an audience response system that allowed the presentation to be interactive. This enabled attendees to fully participate by voting (anonymously of course) using the keypads provided on whether they believed the statements presented during the presentation were fact or fiction. After each presentation, attendees were emailed a survey to complete asking for feedback on the presentations. We received a great deal of positive feedback, and each and every comment made was reviewed and taken into consideration for future presentations.

With that being said, we would like to let everyone know that Setting the Record Straight will continue next year with some different cities to visit and new myths to bust.

Following are five of the most prevalent myths that were busted during the presentations, along with their statistics and rationales:

- **74% of participants did not know that an RDH can purchase prescription drugs to use as part of a dental hygiene therapy.**

  According to the Drug and Pharmacies Regulation Act, R.S.O. 1990, c. H.4 Section 118(3).

  (3) Nothing in this act prevents any person from selling, to a member of the College of Chiropodists of Ontario, the College of Dental Hygienists of Ontario, the College of Midwives of Ontario or the College of Optometrists of Ontario, a drug that the member may use in the course of engaging in the practice of his or her profession. 1991, C. 18, S. 47 (9); 2007, C. 10, SCHED. L, S. 3 (3).

  Simply put, a dental hygienist can obtain a drug to use in the course of administering his or her dental hygiene treatment. An example of this would be obtaining Chlorhexidine to use for in-office irrigation. **Note:** this regulation does not include dispensing Chlorhexidine for home use.

- **70% of participants did not know, or were of the misunderstanding, that a ‘Standing Order’ must be signed yearly.**

  While many offices prefer to sign a standing order yearly, and while it may be good practice, it is not a requirement. The standing order must be signed yearly if it expires yearly. If there is no expiry date on the standing order, it is considered valid until either the dental hygienist who signed it or the dentist who signed it are no longer associated with the specific practice location.

- **70% of participants were unsure or did not know how often cardiopulmonary resuscitation (CPR) must be renewed.**

  According to the guidelines for continuing competency, each dental hygienist involved in clinical practice must hold a current CPR certificate and must be competent in administering CPR if necessary. If a dental hygienist has taken a CPR course and the certificate is valid for three years, then provided the dental hygienist feels competent throughout the three-year period, the CPR would remain current until the noted three-year expiry date. If the CPR certificate has no expiry date, then the certificate is valid for one
year from the date that the CPR course was taken. The CPR certificate expiry date combined with the dental hygienists’ assessment of their competency determines how often CPR must be renewed.

- **50% of participants thought it was ok to proceed on a new client (without doing a full baseline assessment) if a client requested a ‘cleaning only’ and the medical history was clear.**
  The CDHO Standards of Practice requires that the process of care be followed. This requires that an appropriate assessment be done prior to any dental hygiene intervention. When treating a new client it is imperative that the dental hygienist has full baseline data in order to properly design a treatment plan that takes the client’s best interests into account. If a client refuses to let the dental hygienist collect full baseline data, then the dental hygienist may choose to refuse to treat the client, since proceeding without baseline data has the potential to cause more harm than good and may place the dental hygienist at risk for providing substandard care.

- **50% of participants were unsure or did not know if they could take radiographs if the dentist was not in the office.**
  Dental hygienists do not require supervision to take radiographs. What is required according to the Healing Arts Radiation Protection Act, 1990 is a client-specific prescription obtained by an appropriate prescriber for every radiograph that is taken.

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**Myths and Facts**

*As with many areas of life, rumours abound. Here are a few related to the activities of the CDHO, followed by the correct information.*

**Myth:** The CDHO is causing tension between dental hygienists and their employers.

**Fact:** The CDHO’s mandate is clearly articulated in its mission statement, as the College regulates the practice of dental hygiene in Ontario in the public interest. Tension may be caused because of differing value systems, lack of respect for professionalism, financial considerations, or because of competing priorities. Employment concerns should be addressed to the professional associations.

**Myth:** The CDHO has done nothing to curb the proliferation of non-accredited dental hygiene programs.

**Fact:** The CDHO has worked closely with the Ontario Ministry of Training, Colleges and Universities (MTCU), the Commission on Dental Accreditation of Canada and the National Dental Hygiene Certification Board (NDHCB) to solve the non-accredited school problem.

**Fact:** There are currently no non-accredited dental hygiene programs in Ontario that are accepting students. All graduates of non-accredited programs are required to pass the NDHCB exam and then pass a clinical competency assessment.

**Fact:** Due to the problems experienced with the non-accredited dental hygiene programs, MTCU will now consult with the appropriate regulatory authority before approving any new educational programs.

**Myth:** There are different standards of practice for registrants who are authorized to self-initiate and for those who are not.

**Fact:** The CDHO Standards of Practice apply equally to all registrants, regardless of practice setting or authorization to self-initiate.
According to the Canadian Diabetes Association, more than nine million Canadians live with diabetes or prediabetes. Diabetes Mellitus is a chronic condition of accumulated elevated blood glucose levels that presents when the body either does not produce enough insulin (insulin deficient) or cannot use the insulin it produces (insulin resistant). As you will recall from your dental hygiene education, insulin is needed by the body to change blood sugar from food into energy. But did you know that although diabetes can be simply diagnosed with blood testing, nearly one third of adults with diabetes are unaware that they have the disease? Did you know that you can play an important role in identifying clients who are at risk for diabetes by knowing the physical and oral signs and symptoms of diabetes and making the appropriate referral to a medical practitioner? (see Tables 1 and 2)

Approximately 10% of people with diabetes have type 1 diabetes, an autoimmune disease that stops the pancreas from making insulin. The more common type of diabetes is type 2, occurring when the body does not produce enough insulin or cannot use it effectively. People most at risk for developing type 2 diabetes are: those who have close relatives with diabetes; over 45 years of age; overweight and do not exercise regularly; of Aboriginal, Hispanic, Asian, South Asian or African descent; those who developed diabetes during pregnancy; or, those who have delivered a baby weighing over nine pounds. In Canada, the number of people with type 2 diabetes is increasing dramatically due to a number of factors:

- The population is aging.
- Obesity rates are rising.
- Canadian lifestyles are increasingly sedentary.
- Aboriginal people are three to five times more likely than the general population to develop type 2 diabetes.
- Almost 80% of new Canadians come from populations that are at higher risk for type 2 diabetes.

The Oral Health Connection

Persons with diabetes are at an increased risk of oral disease because their impaired host response means they are more susceptible to bacterial infection and have a decreased resistance to pathogenic bacteria. People with diabetes are two to three times more likely than those without to have periodontal disease. For those with poorly controlled blood glucose levels, the risk to periodontal disease is increased even more. In addition, those with diabetes who have periodontal disease find that their blood glucose control is made more difficult. Even perhaps more significant is the increased mortality and morbidity from heart and kidney disease in persons with type 2 diabetes who have periodontal disease.

Your Role

As the oral care professional clients usually see first, dental hygienists are educated to know the early signs and symptoms of both diabetes and periodontal disease. Essentially, dental hygienists are a first defence in the detection and recognition of both disease processes and in the treatment of associated oral manifestations and periodontal disease. Suspicion that a client fits the risk profile for diabetes combined with decreasing periodontal health, or clients with unmanageable periodontitis who fail to respond to treatment or have multiple abscesses or fungal infections warrant a referral to a physician for diabetes screening.

For clients already diagnosed with diabetes, dental hygienists play a key role in educating them about the oral risks associated with their condition and recommending dental hygiene interventions and self-care regimes that will decrease their susceptibility to gingivitis and periodontitis, and help make blood glucose control less difficult.

In treating clients who present with diabetes, dental hygienists should be alert to, and discuss as appropriate, the oral implications of diabetes. Poorly controlled diabetes affects tissue response as well as poor healing in other areas of the body.
There may be times when postponing invasive dental hygiene procedures until blood glucose levels are stable may be necessary. If a client reports a history of recent infections, poor healing, or unstable blood glucose readings, a consultation with their primary health care provider is advised. Depending on the invasiveness of the dental hygiene intervention planned, prophylactic antibiotics may be prescribed by the physician.

People with poorly controlled diabetes, and especially those who smoke, often experience xerostomia. In addition, many of the medications used to treat the diabetic client are associated with a decreased salivary flow. Dental hygienists can help their clients manage their xerostomia by educating them about products and practices available for dry mouth sufferers, and by stressing the importance of being vigilant in plaque and sugar reduction to minimize the risks to oral health.

Diabetic clients should also be advised to watch for, and report, any changes in the mouth. Some of the key symptoms they should watch for are persistent gingival bleeding, halitosis, abscesses, ulcerations, and signs of candidiasis in the mouth or on the tongue.

Timing of dental hygiene appointments are another consideration for diabetic clients. Generally speaking, the best time for a dental hygiene appointment is when the blood glucose level is in the target range and the diabetes medication action is low. If the client takes insulin, a morning visit after a normal breakfast is best. During a dental hygiene appointment, stressed persons release hormones that can affect insulin uptake and blood glucose levels. It is very important that you confirm that insulin/medications were taken at the appropriate time and that your client followed their meal plan. If a client is especially anxious about dental hygiene visits, you may wish to discuss stress reduction techniques and/or consult with her or his physician about possible interventions to keep blood glucose levels stable. Adjustments to the diabetic’s medication may be necessary if they suffer from high stress levels or are required to spend long periods of time in the chair.

Table 1: Signs and Symptoms of Diabetes

<table>
<thead>
<tr>
<th>Physical</th>
<th>Oral</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequent daytime or nighttime urination</td>
<td>Gingival inflammation</td>
</tr>
<tr>
<td>Excessive thirst or hunger</td>
<td>Gingival abscesses</td>
</tr>
<tr>
<td>Unintended weight loss</td>
<td>Increased pocket depths</td>
</tr>
<tr>
<td>Increased fatigue and irritability</td>
<td>Decreased attachment levels</td>
</tr>
<tr>
<td>Blurry vision</td>
<td>Xerostomia</td>
</tr>
<tr>
<td>Poor wound healing</td>
<td>Altered taste or “bad” taste</td>
</tr>
<tr>
<td></td>
<td>Candida infections</td>
</tr>
<tr>
<td></td>
<td>Persistent halitosis with a fruity acetone odour</td>
</tr>
</tbody>
</table>

Early Detection and Treatment

In sum, coping with diabetes is a lifelong challenge for more than nine million Canadians. The goal of treating diabetes is to prevent its symptoms and long-term complications by keeping blood glucose levels as close to an individual’s target level as possible. Managing the disease requires significant self-discipline and self-monitoring by the diabetic. Early detection and treatment can significantly reduce the complications of diabetes. Dental hygienists can play an important role in identifying clients who are at risk for diabetes given that one of the major risk factors for periodontal disease is diabetes. Screening clients, especially those with periodontal involvement, for the signs and symptoms of diabetes and making the appropriate medical referral means that dental hygiene clients will get the early detection and treatment identified in reducing the long-term complications of diabetes. Furthermore, treatment of periodontal disease leads to the resolution of the tissue destructive process, and reduction of local and systemic inflammatory response. There is growing evidence that dental hygiene interventions resulting in the improved periodontal health of diabetic clients also improved poor glycemic control indicating the value of dental hygienists as part of the diabetes care team.

...continued on page 28
CDHO LAUNCHES PHASE III OF PUBLIC INFORMATION CAMPAIGN

The mouth tells your health’s story

The College of Dental Hygienists of Ontario (CDHO) continues to meet its commitment to public education and to increasing public awareness of the regulatory college’s role in the delivery of safe, quality oral hygiene health care through an annual media campaign. This year’s integrated communications program has been launched province-wide with radio spots, print ads in major magazines, billboards and transit shelters. The College has added a digital component to the program using QR codes embedded in the printed materials that link to the CDHO website and special vignettes with further information and a story behind each ad.

There are six core messages built upon two positioning statements. The message positioning is built around the concept that THE MOUTH TELLS YOUR HEALTH’S STORY. The public service message is the CDHO and its registrants are YOUR FIRST DEFENCE IN ORAL HEALTH. The messages and stories revolve around six health conditions that registered Dental Hygienists have the skills, knowledge and judgment to provide qualified clinical decisions and sound advice on. The conditions are oral cancers, diabetes, pneumonia, reflux disease, stroke and eating disorders.

The Quality Assurance Program and the CDHO Knowledge Network serve to keep registered Dental Hygienists current in the identification of many health conditions and diseases that often present in the mouth. Competent oral health practice is the goal and that message is being shared with the health consumer in the context of the public interest and protection role of the College.

In the pages that follow, you’ll see the bold, fresh and informative approach of the artwork and the messages.

Radio stations in Barrie, London, North Bay, Ottawa, Sudbury, Thunder Bay and Toronto will be carrying radio spots. Billboards and transit shelter ads will be located in Toronto and Ottawa. Print ads will also appear in The Canadian Living, Homemakers and Zoomer magazines.

If you have a smart phone, check out the QR codes.

Overall Impressions of Dental Hygienists
College of Dental Hygienists of Ontario: Awareness and Attitude Study October 2011

<table>
<thead>
<tr>
<th>Strongly agree</th>
<th>Somewhat agree</th>
<th>Somewhat disagree</th>
<th>Strongly disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>57%</td>
<td>38%</td>
<td>4%</td>
<td>1%</td>
</tr>
</tbody>
</table>

Total Agree 96%

Overall, I am satisfied with the care that I receive from my dental hygienist

<table>
<thead>
<tr>
<th>Dental hygienists are an important member of your oral health team.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly agree</td>
</tr>
<tr>
<td>65%</td>
</tr>
</tbody>
</table>

Total Agree 96%
CDHO LAUNCHES PHASE III OF PUBLIC INFORMATION CAMPAIGN

Billboards and Transit Shelters

(Six weeks, from November to December 2011)
The Toronto and Ottawa areas will be part of the outdoor advertising program.
A full listing of the locations is available on the CDHO website.

Embedded with the print material is a QR code. You may have heard of them. You may have used one. QR codes are part of digital communications and by simply scanning the code with your smart phone you will be linked to additional information. The CDHO QR code will take you to the vignette stories behind each ad.

www.cdho.org
CDHO LAUNCHES PHASE III OF PUBLIC INFORMATION CAMPAIGN

Print Ads in Publications

ZOOMERS
DECEMBER 2011
ISSUED NOV/DEC

HOMEMAKERS
DECEMBER 2011
ISSUED NOV/DEC

CANADIAN LIVING
JANUARY 2012
ISSUED NOV/DEC/JAN

2.6 million Canadians = Type 1, 2

Diabetes diagnoses increase 7% every year and have increased almost 33% since 2006. In 2011, an estimated 2.6 million Canadians have been diagnosed with diabetes. There is an increased risk of developing diabetes after age 40.

Please see the article on the topic of diabetes in this issue.
CDHO LAUNCHES PHASE III OF PUBLIC INFORMATION CAMPAIGN

30-Second Radio Spots

Six Regions of Ontario | Barrie | London | North Bay/Sudbury | Ottawa | Thunder Bay | Toronto
Six-week radio campaign running November 1 to December 15, 2011.

CDHO – One – ORAL CANCERS
THE MOUTH TELLS YOUR HEALTH’S STORY.
Smoking and drinking alcohol increase the risk of developing oral cancers. There are 3,400 new cases of oral cancer each year among Canadians 50 and older. The College of Dental Hygienists of Ontario wants the public to know Regulated Dental Hygienists are YOUR FIRST DEFENCE IN ORAL HEALTH, trained and alert to the early signs of Oral Cancers.
FOR MORE INFORMATION GO TO WWW.CDHO.ORG

CDHO – Two – DIABETES
THE MOUTH TELLS YOUR HEALTH’S STORY.
Heredity, obesity, inactive lifestyle and age are contributing risk factors to Type 2 Diabetes. Diabetes has increased 33% since 2006. The College of Dental Hygienists of Ontario wants the public to know Regulated Dental Hygienists are YOUR FIRST DEFENCE IN ORAL HEALTH, trained and alert to the early signs of Diabetes.
FOR MORE INFORMATION GO TO WWW.CDHO.ORG

CDHO – Three – DISORDERS
THE MOUTH TELLS YOUR HEALTH’S STORY.
Teenage girls and young women are more likely than male counterparts to have eating disorders. Eating disorders are the THIRD most common chronic illness among adolescent girls. The College of Dental Hygienists of Ontario wants the public to know Regulated Dental Hygienists are YOUR FIRST DEFENCE IN ORAL HEALTH, trained and alert to the early signs of Eating Disorders.
FOR MORE INFORMATION GO TO WWW.CDHO.ORG

CDHO – Four – STROKE
THE MOUTH TELLS YOUR HEALTH’S STORY.
You can’t control your age, gender or ethnicity. But you can do something about obesity, high cholesterol and blood pressure. The risk of stroke doubles every 10 years after age 55. The College of Dental Hygienists of Ontario wants the public to know Regulated Dental Hygienists are YOUR FIRST DEFENCE IN ORAL HEALTH, trained and alert to the early signs of Heart and Stroke Disease.
FOR MORE INFORMATION GO TO WWW.CDHO.ORG

CDHO – Five – REFLUX
THE MOUTH TELLS YOUR HEALTH’S STORY.
Gastro-Esophageal Reflux disease or GERD is more than just “heartburn.” Over half of the adult population suffers with this condition which can seriously damage the esophagus. The College of Dental Hygienists of Ontario wants the public to know Regulated Dental Hygienists are YOUR FIRST DEFENCE IN ORAL HEALTH, trained and alert to the signs of Reflux Disease.
FOR MORE INFORMATION GO TO WWW.CDHO.ORG

CDHO – Six – PNEUMONIA
THE MOUTH TELLS YOUR HEALTH’S STORY.
Adults 65 and older and children over age 2 are at high risk of pneumonia. Between 200,000 and 300,000 Canadians develop pneumonia every year. Oral plaque can be a contributing factor. The College of Dental Hygienists of Ontario wants the public to know Regulated Dental Hygienists are YOUR FIRST DEFENCE IN ORAL HEALTH, trained and alert to Pneumonia risks.
FOR MORE INFORMATION GO TO WWW.CDHO.ORG

Go to the CDHO website for a full listing of the radio stations running spots in these six markets.
Quality Assurance
By Jane Keir, RDH, BSc, BEd

2013 Portfolio Selection

In mid-January 2012, all dental hygienists who graduated prior to 2006 and who have never previously been selected through the random selection should expect to receive a letter requesting submission of their portfolio by January 31, 2013. This selection will include approximately 2100 dental hygienists in Ontario.

At the end of January, you will be able to check online to see if you are required to send in your portfolio. Go to www.cdho.org, click on the “Registration” tab and then on the “Address Change” link. To access your personal information you will need to log in. Once inside the address change page, you will see your last and next portfolio assessment year. If the “Next Assessment Year” section states “Unknown” you have not been selected to submit your portfolio.

A Fresh Look—Using the new Standards of Practice in Goal-Setting

Now is the time when dental hygienists across the province should consider reflecting on their dental hygiene practices with an eye to setting new goals for their portfolio for the upcoming year. On January 1, 2012, the new CDHO Standards of Practice will come into effect.

The Standards document is an excellent starting point for dental hygienists wishing to self-assess their dental hygiene practices, to identify areas that can be enhanced and to determine what skills or knowledge would be needed to help make changes. Many dental hygienists have indicated that they have difficulty setting goals and may find using this document may be a particularly helpful tool. If you do not feel that you need additional knowledge to meet a particular Standard, then this is likely not a good goal for you. The chart below shows some sample goals related to selected Standards.

<table>
<thead>
<tr>
<th>Standard</th>
<th>Sample Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Standard 1 e)</strong> Providing information about oral health and access to oral health care for clients, other professionals and the public.</td>
<td>Learn about community resources and how to assist clients to connect with these.</td>
</tr>
<tr>
<td><strong>Standard 3 d)</strong> Integrating new knowledge, services and/or technology into the appropriate practice environments only after a critical review process has been completed.</td>
<td>Investigate and assess current research in the use of lasers in dental hygiene practice.</td>
</tr>
<tr>
<td><strong>Standard 8.4 a)</strong> Ensuring that current scientifically accepted infection prevention and control procedures are in place and practised.</td>
<td>Investigate current scientifically accepted infection control guidelines, assess current practice and modify practices as needed to meet guidelines.</td>
</tr>
<tr>
<td><strong>Standard 8.4 g)</strong> Managing client pain and/or anxiety by discussing options for the control or pain and anxiety with the client, selecting and providing clinical techniques for the control of pain and anxiety and evaluating the effectiveness of the pain control method selected.</td>
<td>Conduct a critical review of current technologies and products available for pain control.</td>
</tr>
</tbody>
</table>
2012 Portfolio Submission

Registrants who are required to submit their portfolios in January of 2012 are reminded that the College will start accepting submissions on January 1, 2012.

E-mailing your professional portfolio:

• E-mail the professional portfolio to: qualityassurance@cdho.org

• You should receive confirmation by e-mail within three business days.

• You can use your e-mail address in lieu of a signature, ONLY if you are submitting your portfolio by e-mail.

Mailing your professional portfolio (by post):

• Please submit a photocopy of your professional portfolio, as the one you submit for the assessment will NOT be returned. Portfolios must be kept on file as per the Quality Assurance policy and procedures handbook.

• Photocopies should be clean, clear and legible.

• Do not staple or bind the pages. If you wish, the pages may be paper-clipped.

• Mail the professional portfolio to:
  Quality Assurance
  College of Dental Hygienists of Ontario
  69 Bloor St. E, Suite 300, Toronto ON M4W 1A9

RDH Expertise for RDHs

CDHO practice advisors provide confidential consultations to dental hygienists who seek assistance with issues that directly or indirectly affect the delivery of safe, competent, ethical dental hygiene care.

To reach a CDHO practice advisor, call or email,
416-961-6234 or 1-800-268-2346 to reach:

Robert Farinaccia, RDH, x 237, rfarinaccia@cdho.org
or
Jane Keir, RDH, x 235, jkeir@cdho.org
For regulated health care professionals in Ontario, the definition of sexual abuse is not as simple as it sounds. When one thinks of sexual abuse, the notion of forced or undesired sexual behaviour by one person upon another may come to mind. However, as registered dental hygienists in Ontario, regulated by the Regulated Health Professions Act, 1991 (RHPA), this definition is not completely accurate. Under the RHPA, the definition of sexual abuse is very broad and includes any of the following conduct with respect to a client:

- Sexual intercourse or other forms of sexual relations;
- Touching of a sexual nature; or
- Behaviour or remarks of a sexual nature.

Below are some of the most common inquiries we receive at the College regarding sexual abuse. These are being published to help dental hygienists gain an accurate understanding of exactly what the RHPA considers sexual abuse.

**Is telling a client a joke that has sexual content considered sexual abuse?**

According to the RHPA’s definition of sexual abuse, telling a client a joke that has sexual content is considered sexual abuse. This definition would also include the dental hygienist laughing at a sexual joke told by a client in the presence of another client. Maintaining clear and firm boundaries with clients is essential to avoid conduct that could be perceived as sexual. When a client initiates such behaviour by telling a joke or engaging in flirtatious behaviour, the dental hygienist should politely but firmly put a stop to it.¹

**May a dental hygienist treat their spouse or boyfriend/girlfriend?**

The definition of sexual abuse includes the treatment of spouses even if there was a pre-existing spousal relationship prior to dental hygiene treatment being performed. There is no room for interpretation. It is important to note that a client’s consent to treatment in these cases is irrelevant, as it still amounts to sexual abuse as defined by the RHPA, and by this definition sexual abuse can be consensual.²

Should a mandatory report, complaint or other information be brought to the attention of the College that a dental hygienist is treating her or his spouse or someone with whom the dental hygienist is having an intimate relationship with, this could lead to a referral to the Discipline Committee. The mandatory penalty for a finding of sexual abuse, even where the client is one’s spouse, is revocation of the dental hygienist’s certificate of registration for a minimum of five years.³

Dental hygienists who treat their spouses are not only acting contrary to the legislation, but are also putting their co-workers in a very awkward situation where their co-worker may be torn between reporting or not reporting. In this situation it is very important to remember that not reporting is considered professional misconduct and carries a punishable fine (see the question regarding not filing a mandatory report below). Dental hygienists should ensure that all co-workers are familiar with the regulations regarding sexual abuse so that the situation noted above can be avoided.

**What if a dental hygienist wishes to date a client?**

If a dental hygienist is considering dating a client, they should first terminate the dental hygienist/client relationship. Arrangements should be made for another
dental hygienist to treat the client. The dental hygienist should then wait an acceptable time before beginning to date the client. An appropriate time depends on the circumstances of each case and the College strongly urges registrants to err on the side of caution when determining the appropriate timeframe. Also, to avoid any potential issues that may arise in the future, the dental hygienist would be wise not to treat the client again (should their personal relationship not work out).

Is treating family members considered sexual abuse?

Under the RHPA, no rule exists that constitutes treating family members as sexual abuse. However, the CDHO discourages the practice of dental hygienists treating family members as it can be viewed as a conflict of interest. Treating one’s own family may open the door to conflict if the treatment is not successful or if the family member is not compliant with treatment recommendations. Having an unbiased dental hygienist will ensure objectivity and may avoid the conflicts inherent in confiding personal information to family members.

If a dental hygienist knows of a regulated health care professional that is involved in an intimate relationship with a client, must they report this?

If a dental hygienist knows of a health care professional that is treating a client and is involved in an intimate relationship with that client, then according to the RHPA the dental hygienist is obligated to submit a mandatory report, since this is considered sexual abuse. A dental hygienist is required to report sexual abuse of a client by any regulated health care professional.

Dental hygienists are required to:

- Report information obtained in the course of practising their profession.
- Report if they know the name of the practitioner who was involved in the alleged abuse. (They are not required to file a report if they do not know the name of the alleged abuser.)
- Obtain the client’s permission to include his or her name in the report and get written consent as an indication.
- Submit a written report within 30 days to the Registrar of the appropriate College, or if there is reason to believe the abuse will continue or abuse of other clients will occur, the report must be submitted immediately.

In the scenario above, if the client refuses to give their name, must the dental hygienist still submit a report?

The dental hygienist is still required to submit a report but must not include the client’s name in the report. The fact that the dental hygienist tried to obtain consent but the client refused, should be included in the report as well.

What if the dental hygienist decides not to file a mandatory report?

Often times, clients will disclose to a regulated health care professional that they have been sexually abused.../continued on page 24

Professional Input Sought

The Health Professions Regulatory Advisory Council is looking for input on the issue of mandatory revocation provisions and treatment of spouses by regulated health care professionals.

For more information, visit:

because they may be embarrassed to report directly to the appropriate authorities themselves. Clients may also be aware of a regulated health care professional’s obligation to report and hence will disclose that they have been sexually abused to the dental hygienist. Not reporting sexual abuse (in any form) is considered professional misconduct. Failure to report sexual abuse of clients is an offence under the RHPA and has a punishable fine of up to $25,000 for a first offence and up to $50,000 for a second offence.

If a dental hygienist is at a social function and while in conversation with someone, finds out about a regulated health care professional that sexually abused a client/patient, is the dental hygienist obligated to report this?

According to the RHPA, a regulated health care professional is required to make a mandatory report if the information was obtained in the course of practising his or her profession. Since the above information was obtained while the dental hygienist “was not practising their profession” there is no obligation to report. However, considering the safety and well-being of the public, the dental hygienist should seriously consider reporting this information to the appropriate regulatory college.

If a dental hygienist files a mandatory report, is he or she protected in any way?

Under the RHPA, reporters are given legal protection from any retaliation by the registrant who is the subject of the report, provided that the report was made in good faith.

If a dental hygienist is ever in doubt as to whether something should be reported or not, they can call the College and speak to a practice advisor (anonymously if they wish) for advice.

References


2. ibid. Page 98.

3. ibid. Page 98.


In recent years, dental hygienists have been experimenting with different forms of business structures. The CDHO is supportive of any business structure that enables a dental hygienist to fulfill her or his professional responsibilities. Two recurring issues are:

1. Profit Sharing Structures
2. Dental Hygiene Professional Corporations

**Profit Sharing Structures**

The CDHO, like most Regulated Health Professions Act, 1991 (RHPA) Colleges, has liberalized the way it has interpreted the prohibition against conflict of interests. In the case of revenue, fee or income splitting with others, the recently circulated conflict of interest regulation permits this in the following circumstances:

- An associated registrant or a dental hygiene professional corporation;
- A registrant of another College or a health care professional corporation; or
- In accordance with a written agreement that states that the registrant has the responsibility for, and control over, all the clinical and professional aspects of the dental hygiene practice, including record keeping and billing.

Translated into specifics, this means that investors can have an interest in the business aspects of the practice as long as there is a proper written agreement in place that gives the dental hygienist control over all clinical and professional matters, including the scheduling of clients and billings. For example, in the case of a multidisciplinary clinic owned by a corporation that manages a chain of similar clinics, the clinic could administer the billing so long as the dental hygienist sets or approves the billing rules and monitors, perhaps on a spot-check basis, compliance with those billing rules. This arrangement would be appropriate because the dental hygienist would retain control over scheduling of clients and access to any financial information, including billings in her or his name.

A proper written agreement, while perhaps prudent, is not required with other dental hygienists or regulated health care professionals who are governed by another RHPA College and, presumably, have similar professional standards and values.

**Dental Hygiene Professional Corporations**

The RHPA authorizes one or more dental hygienists to establish a health care profession corporation for the purposes of practising their health care profession. Dental hygienists cannot practice the profession through any other type of corporation.

However, only dental hygienists can be shareholders of a dental hygiene professional corporation. This restriction is set out in the Business Corporations Act, 1990 and the regulations made under that Act that apply to a health care profession corporation established under the RHPA. That explains why the name of the corporation must include the surname of one or more of the shareholders and must indicate the health care profession to be practised by members of the College through the corporation.1

The unregistered owner or business entity – other than a dental hygiene professional corporation – cannot hold herself or himself out as practising dental hygiene or as performing controlled acts. So key documents of the business (e.g. invoices) must make it clear that it is the dental hygienist that is offering and providing the professional service.

Other types of corporations can manage the operational aspects of the practice (e.g. providing premises, equipment and support staff). However, such management corporations cannot practise dental hygiene and must be careful not to leave the impression that they can do.

.../continued on page 28

1 There are slightly different rules that apply to medical and dental professional corporations.
Sterilization and the Importance of Sterilizer Monitoring

By Jane Keir, RDH, BSc, BEd

The regulatory colleges for health care practitioners in Ontario are responsible to ensure that the clients of their registrants/members receive safe, effective care, including ensuring that appropriate and acceptable infection control protocols are followed. In a recent news release from the College of Physicians and Surgeons of Ontario (CPSO), the public learned of an Ottawa medical clinic that failed an inspection under the Out-of-Hospital Premises Inspection Program administered by the College. The clinic was found not to have been appropriately cleaning equipment used to conduct gastroscopies and colonoscopies. Letters were sent to 6,800 patients informing them of a possible infection risk. The CPSO has taken necessary steps to ensure that the public is protected from further risk.

The CDHO Standards of Practice, which take effect in January 2012, state that “Dental hygienists have an obligation to their clients to establish and maintain practice environments that have organizational structures, policies and resources in place that are consistent with legal, professional and ethical responsibilities that promote safety, respect and support for all persons within the practice setting.” One of the most critical ways that dental hygienists meet this practice standard is through ensuring that their infection control protocols and practices are performed, based on current scientifically accepted infection control guidelines.

In a recent survey commissioned by CDHO, Ipsos Reid surveyed the public to assess their awareness of, and attitudes towards, dental hygienists. One component of the survey included the assessment of public perception related to sterilization and sterilizer monitoring. The survey results are considered accurate to within +/- 3.5 points 19 times out of 20. The key findings of the survey related to sterilization and sterilizer monitoring included the following:

- There is unanimous support for the idea that it is important to sterilize dental instruments and a nearly unanimous belief that the instruments used in the dental/dental hygiene practices they frequent are being sterilized correctly.
- When an explanation was provided about the purpose of spore-testing, Ontarians placed a high degree of importance on spore testing and on it being performed correctly and at the required frequency.
- Ontarians are very confident that the dental/dental hygiene office they frequent is using spore-testing to validate the proper sterilization of dental equipment.
- Given the choice, Ontarians are much less likely to frequent a dental/dental hygiene office that does not conduct spore testing.
- Ontarians believe that the dentist is responsible for ensuring that spore testing is being done correctly but agree that if the dentist is not carrying out this responsibility, then it is the responsibility of the dental hygienist to do so.

Through the Quality Assurance (QA) Program, dental hygienists are required to record the infection control practices and procedures used in their daily practice as part of the Typical Day in their professional portfolio. The QA assessors use criteria based on current infection control guidelines in their assessment of the professional portfolios. Failure to provide evidence that these guidelines are followed is a contributing factor leading to an on-site audit of a dental hygienist’s practice environment.

In the history of the QA Program, 237 on-site visits have occurred. Of these, 215 dental hygienists have successfully demonstrated to the assessor that they were using acceptable infection control techniques, including...
providing evidence of spore testing with acceptable results and at the required frequency. Of the 22 remaining dental hygienists, 19 demonstrated compliance with accepted protocols at or before their second visit, two resigned from the College prior to their second visit and one registrant has a follow-up visit scheduled. These statistics provide overwhelming evidence that demonstrates that dental hygienists in the province are dedicated to meeting the expectations of their clients in regards to infection control procedures and sterilization/sterilizer monitoring.

## How Are Sterilizers Properly Monitored in Practice?

The effectiveness and proper performance of a sterilizer must be confirmed through a combination of three types of monitoring: physical or mechanical; chemical; and, biological. Use of one type of indicator does not replace the need to use the other two types.

### Physical or Mechanical Indicators

Physical indicators include all devices used to assess cycle time, temperature and pressure. These include examining the sterilizers printout, if available, and by observation of the gauges or displays on the sterilizer. Although correct readings do not provide proof of sterilization, they can be used as an indication that a sterilizer may be malfunctioning. Each cycle should be observed to ensure that numbers in the manufacturer-recommended target ranges are being achieved.

### Chemical Indicators

Chemical indicators are those that use chemicals sensitive to heat to assess changes that have occurred during the sterilization cycle. These respond to changes in variables such as temperature, presence of steam or processing time. Examples of chemical monitors include autoclave tapes and sterilizer bags with indicators that change colour when a parameter is reached. Chemical strips are designed to be placed inside sterilization bags and may also be used for verification of sterilizing conditions. These indicators also serve a second purpose in allowing operators to verify if a package has been exposed to the sterilization process. Like physical or mechanical monitoring, these indicators do not indicate that a package is sterile, but rather only that the measured parameter has been reached and a failed chemical test may be an early indication that a problem may exist.

### Biological Indicators (BI or Spore Testing)

Biological indicators use highly resistant and living microorganisms (spores) impregnated on strips or contained in vials to monitor the sterilization process and, according to all current evidence-based infection control guidelines, their use is the most accepted method of ensuring sterilization has occurred.

For quality control purposes, these systems work by using two identical strips or vials from the same lot. The “test” strip or vial is processed within a normal sterilization load. The second strip or vial is used as a “control” and is not subjected to the sterilization process. When the two are incubated and cultured to determine if the spores have survived, those from the “test” strip or vial should be completely inactivated and not grow (negative result) while those from the “control” should survive and grow (positive result). Current evidence-based infection control guidelines recommend testing at least weekly. Procedures should be developed to follow if any “test” strips or vials show a positive result, as this is an indication that sterilization has failed. Where mechanical monitoring has indicated proper sterilizer function, a second spore test should be performed to rule out operator error. The sterilizer should be temporarily taken out of service until the results of the second test are obtained. If the physical and chemical monitors indicate that the sterilizer is functioning properly and the repeat test is negative, the sterilizer can be put back into service. A second positive result indicates the need for service and the sterilizer should not be used until it has been inspected and repaired. Prior to putting it back into service, three spore tests should be performed to confirm sterilization is occurring.

.../continued on page 28
Availability of Monitoring Systems

There are currently many different in-office and commercial mail-out biological monitoring systems available for use. In-office monitoring may be more cost-effective with no delay between testing and the receipt of results but are technique-sensitive and require careful handling to achieve accuracy. Commercial mail services are convenient, require no equipment commitment and the companies confirm the results, but they can be more costly and there is a delay in receiving results due to mail delivery schedules. Each office should assess their needs to determine which system will work best for them.

With all types of monitoring, it is crucial that manufacturers’ instructions be followed for proper use and storage. Indicators that are beyond the expiry date must be replaced and only used for the sterilizer type for which they are recommended.

CDHO Requirements

The CDHO record keeping regulation requires that equipment servicing records must be kept for all instruments or equipment used for examining, treating or rendering services to clients including that used to sterilize equipment or instruments. Results of the monitoring, repair and preventive maintenance measures related to sterilizers must be maintained including a log of the biological monitoring results.

Interested in reading more about sterilization monitoring?

Go to the Centers for Disease Control and Prevention website at www.cdc.gov or to the Provincial Infectious Disease Advisory Committee website at www.pidac.ca.

Table 2: Resources to Learn More About Diabetes

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<td>• Canadian Diabetes Association: <a href="http://www.diabetes.ca">www.diabetes.ca</a></td>
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<td>• Asian American Diabetes Initiative: <a href="http://www.aadi.joslin.org">www.aadi.joslin.org</a></td>
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<td>• Joslin Diabetes Center: <a href="http://www.joslin.org">www.joslin.org</a></td>
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<td>• Health Canada: <a href="http://www.hc-sc.gc.ca/hc-ps/dc-ma/diabete-eng.php">www.hc-sc.gc.ca/hc-ps/dc-ma/diabete-eng.php</a></td>
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<td>• CDC’s Division of Diabetes Translation: <a href="http://www.cdc.gov/diabetes">www.cdc.gov/diabetes</a></td>
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<td>• World Health Organization: <a href="http://www.who.int/mediacentre/factsheets/fs312/en">www.who.int/mediacentre/factsheets/fs312/en</a></td>
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Structuring Your Practice continued from page 25

The RHPA makes it clear that the professional, fiduciary and ethical obligations of dental hygienists to clients are not diminished by the fact that they are practising through a health profession corporation. In fact, they are strengthened as they equally apply to the corporation and to its directors, officers, shareholders, agents and employees.

Conclusion

Innovative ways of structuring one’s practice is to be encouraged. Such structures can facilitate greater access by the public to necessary services and promote inter-professional collaboration. However, dental hygienists need to keep in mind the limitations imposed by the Business Corporations Act and conflict of interest requirements.
What to Expect From Failure to Submit Your Professional Portfolio to the Quality Assurance Committee

By Evelyn Waters, BA

It’s getting to that time of year again where those registrants who were selected in 2011 to submit their professional portfolio must do so by January 31, 2012. If you are having difficulties with this requirement, don’t ignore it. It may be that you are thinking of resigning your certificate of registration or you are encountering some personal and/or medical issues. Call the Quality Assurance (QA) department and discuss what options may be available to you. Failure to comply with the QA requirement may result in the matter being referred to the Inquiries, Complaints and Reports Committee (ICRC).

If you are not sure if you have been selected, you can check on-line under the Registration tab and log in to “address change”. Moving and not updating your contact information with the CDHO is not considered an acceptable excuse for non-compliance.

Once a matter has been referred to the ICRC, the registrant is provided with an opportunity to make a submission to the ICRC as to why she or he did not comply with the QA Committee requirement. The ICRC may approve the appointment of an investigator who will schedule an interview with the registrant. Even if the registrant complies with the QA Committee requirement after being referred, the ICRC will still have to address the issue of initial non-compliance. The ICRC regards non-compliance seriously.

In some cases, the registrant may resign their certificate of registration due to personal or medical reasons. In these cases, the ICRC will normally take no further action, but the registrant will be required to immediately comply with the requirements of the QA Committee should they re-apply for registration with the CDHO in the future. However, if an official investigation has already been started before the registrant resigns, the public register will state that the registrant resigned while under investigation.

There are several decisions that can be made by the ICRC. The ICRC looks at each case on an individual basis. If the members of the Committee believed that, based on the registrant’s submission, there were extenuating circumstances and the registrant has since complied with the QA Committee, they may determine that no further action is necessary. Other action the Committee may take includes requiring the registrant to appear before it to be cautioned. This is a meeting conducted by the ICRC Committee in which they relate their concerns about the issue directly to the registrant. The Committee could require the registrant to complete a specified continuing education or remediation program, which could include an ethics and/or jurisprudence course at her or his own expense. If the matter is very serious and/or it appears that the registrant is unwilling to cooperate in the investigation process, the matter could be referred to the Discipline Committee, which has the power to suspend or revoke a registrant’s certificate of registration.

Discipline Decision

SUMMARY & REASONS

Darlene Magill: 005492

The Inquiries, Complaints and Reports Committee referred Ms. Darlene Magill to the Discipline Committee to hold a hearing relating to allegations that she contravened the Regulated Health Professions Act, 1991, the Dental Hygiene Act, 1991, or the regulations thereunder and engaged in conduct that was unbecoming a dental hygienist, was disgraceful, dishonourable or unprofessional in that it was alleged that she contravened a standard of practice, failed to keep records in accordance with the Standards of Practice or as required by the regulations, falsified a record relating to the registrant’s practice, signed or issued a document that the registrant knew or ought to have known contained a false or misleading statement and counselled or assisted in the submission of false or misleading accounts or charges to clients or in respect of their care.

Prior to a discipline hearing date being set in this matter, Ms. Magill signed an Undertaking agreeing to resign from the College and never to re-apply for registration as a dental hygienist with the College. Therefore, a Panel of the Discipline Committee agreed to adjourn the disciplinary proceedings against her indefinitely.
In May 2011, Chris Janssen, RN, Assistant Director of Care, Fairview Mennonite Home, Cambridge Ontario and Fran Richardson, Registrar/Chief Administrative Officer, College of Dental Hygienists of Ontario (CDHO) presented at the Ontario Association of Non-profit Homes and Services for Seniors (OANHSS). The topic was Benefits of the Dental Hygienist in Long-Term Care. The study was supported by a CDHO research grant, but the CDHO did not participate directly in the content of the study.

Studies have shown that a decline in oral health can lead to a decline in general health. As a Best Practice Spotlight Organization, Cambridge’s Fairview Mennonite Home chose to implement the Registered Nurses’ Association of Ontario’s (RNAO) oral care guideline http://www.rnao.org/Page.asp?PageID=122&ContentID=1567 leading to a research study with the CDHO about the effectiveness of having an in-house dental hygienist. In the past, Fairview had difficulties in securing a dentist who would attend to residents on-site. This is not an unusual situation and one that prompted the request for an amendment to the Dental Hygiene Act, 1991 to permit dental hygienists to treat clients external to a dental office or without dentist oversight.

Needs Assessment

A needs assessment was conducted with the permission of the residents between September 2008 and January 2009 by a dental hygienist and the Director of Care at the Fairview Mennonite Home. The information gathered indicated that there were a number of poor practices in regards to oral health within the nursing department. It appeared that these poor practices had contributed to signs of periodontal disease, oral infections, loose teeth, extreme malodour, decay and pain. Discussion with the Home’s administration led to a realization that oral health practices needed to be improved as they were aware that the presence of oral disease could put the resident at risk for other health concerns.

Data Collection

A dental hygienist familiar to the residents was contracted to note the presence of plaque, gingivitis, decay, odour, lesions, abscesses and the relative fit of dentures, if present. A total of 76 residents received initial assessments. Based on the initial assessment, the dental hygienist recommended an individual care plan for each resident.

Interventions

All residents who agreed to participate were supplied with a battery-operated toothbrush. A few residents refused the battery-operated toothbrush and preferred the use of a manual toothbrush. The same commercial toothpaste was supplied to the participants and as per their individual care plan, they were introduced to one or more of the following: interproximal brush, sulcular brush, denture brush, floss, interdental stimulators and/or mouth rinses. Their oral care regime was monitored via a daily checklist to record brushing frequency and any problems that were encountered. In addition, educational packages related to the benefits of oral care were provided to the residents’ families to include them in the process and to assist them in understanding the Home’s ultimate goal of sustaining quality oral hygiene care for the residents.

Outcomes

There was an overall increase in the awareness of the importance of oral health resulting in a desire by both residents and care-givers to make changes in the oral health regime. Of the 57 residents who completed the study, 47 showed an improvement in their oral health; 10 residents showed no improvement in their oral health and their physical health declined also. Seven residents died during the time of the study.

As a result of this very basic study, Fairview Mennonite Home has now assigned a specific staff member to follow up on the dental hygienists’ assessments to ensure that recommendations are followed up on and implemented.
in a specific time frame. Families are now taking responsibility to make dental appointments and arrange for transportation for their family member in residence. The nursing staff has been empowered to advocate for the oral health of the residents by developing a daily flow sheet for staff accountability and by developing an oral health assessment tool to be used by registered staff to assess those residents not being seen by a dental hygienist. Management is even more supportive of oral health initiatives than they were before implementing the project.

In addition, the Home has now been able to acquire both a dental hygienist and a denturist who will provide services for the residents on-site. As of this writing, the Home had still not retained the services of a dentist who would attend to the residents on-site. One of the companies that does provide dentist’s services has indicated that it will only see the residents if they have exclusivity, meaning that the residents could no longer be seen by the dental hygienist or denturist of their choice.

**Conclusion**

Both the staff and the residents in the Fairview Mennonite Home benefitted from this very basic study. The residents were now receiving preventive oral hygiene care and experiencing cleaner mouths, while the staff had an increased appreciation for the role of oral health in overall health and comfort of the residents. Additional, more rigorous studies in this area would be of value.

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## New Registrants

### May 28, 2011 to November 11, 2011

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### Milestones

- **WINTER 2011**
- **MARCH 2011**

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### Registrant Changes

- **FALL 2011**
- **MILESTONES**
McCUTCHEON, Chrystal Anne Elaine 014967
McDONNELL, Lauren Christine 015036
McFadden, Andrea 014976
McFadden, Jenny 015304
McGare, Rachel Alexandra 015043
McKEAN, Mary Diane 015341
McLEAN, Raeline 015069
McLEOD, Emily 015075
McNAUGHTON, Veronika 015443
MEAGHER, Sarah-Jane 015113
MELNIK, Ashley Michelle 015259
MENG, Rong 014998
MENHEERE, Kathleen Penney 015044
MERIN, Hayley 015237
MICHENEL, Melissa 014994
MICHON, Valerie 015094
MIRZADRA, Valda 015438
MITU-BERICUAE, Cabi 015287
MONTGOMERY, Tiffany Marie 015107
MONTGOMERY, Julie 015421
MOONEY, Rachel Lynn 015258
MOREO, Ruby 015419
MORETTI, Bianca 015497
MORLAN, Jasia 015161
MORNEAUX, Jacob, Veronique 015303
MORNEAUX-Shields, Desiree 015329
MORRISON, Jacklyn 015181
MORRISON, Samantha 015396
MORECUSA, Stephanie 015246
MOOTHERSILL, Tamara Lynne 015336
MUFORD, Nicolette Rhianna 015430
MUHAMMAD, Bibi Hajir 015414
MUNAVISH, Stephanie 015463
MUMRY, Paige 015199
MYERS, Brianna Kate Lynn 015211
NAKZADA, Stephanie 015444
NASIN, Oskouei, Maryam 015289
NAUS, Jori 015479
NESSIM, Sherif 015369
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NG, Nora 015098
NG, Fanny 015402
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NGUYEN, Theresa 015480
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POPESCUL, Marinela 014969
PORSKAMP, Adrienne 015273
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STAKLI, Sterki 015215
STEPHEN, Erin Lindsay 015349
STEVENS, Becky 015407
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registrant STATUS REPORT
**Authorized for Self-Initiation**

*May 28, 2011 to November 11, 2011*

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Munoz, Agnes 012585
Naismith, Andrea Jeanne 012670
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Yurchuk Caroline 005724
Zaitzky, Barbara Ann 007000
Zhu, Xiao Ping 013004
Zinn, Erica 012623
Zuidersma, Andrea Kim 009257

Reinstated
May 28, 2011 to November 11, 2011

Atkinson, Katrin Elizabeth 009394
Brooks, Betty Jean 005912
Han, Ting 010492
Khan, Sameera 013957
Mertol, Ferhat 012374
Patterson, Suzanne 006816
Ranger, Chelsea Lynne 010547
Rice, Michelle 012554

Resignations
March 28, 2011 to November 11, 2011

Boozan, Kaitlyn Jennifer 013328
Cameron, Patricia 001470
Dick, Lynsay 008889
Edstrom-Genest, Christina 005050
Holt, Jayne Ann 000436
Labelle, Sylvia Janet 000814
Lagace, Amanda Colleen 014681
Leclaire, Anne Dallas 002047
Madden, Carol Ann 002873
Magill, Darlene 005492
Radbourne, Caroline 004422
Renaud, Catherine 013251
Rowe, Carolyn Ann 000671
Second, Donna Mae 001217
Smith, Deborah J 001141
Sonke-Buck, Elisabeth C M 011998
Tabbara, Iulia 005024
Toor, Mandip 014576
Yaksich, Gayle Yolanda 001262
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Did you attend one but would like to participate again?

If so, you are welcome to view a recording of the Setting the Record Straight Webinar that was taped live November 16, 2011.

Please follow the link from the CDHO website.