



FOR OFFICE USE ONLY
Received:
Registration No.:
Registration Date:

COLLEGE OF DENTURISTS OF ONTARIO

APPLICATION FORM FOR CERTIFICATE OF REGISTRATION

PERSONAL INFORMATION

Legal Surname: _____ Given Name: _____

If name on documentation submitted to the College is different from above please provide copy of legal document certifying change.

Date of Birth (day/month/year): _____ Gender: _____

WORK STATUS

Canadian Citizen _____ Landed Immigrant _____ Other Authority to Work in Canada _____

Contact Information:

Street _____ Suite# _____ City _____ Prov./State _____ Postal Code/Zip _____

Telephone _____ Facsimile _____ Email _____
() _____ () _____

Business / Practice:

Street _____ Suite# _____ City _____ Prov./State _____ Postal Code/Zip _____

Telephone _____ Facsimile _____ Email _____
() _____ () _____

LANGUAGE PROFICIENCY

Language of Training:

English _____ French _____ Other (please specify) _____

(PLEASE REFER TO REGISTRATION INFORMATION LANGUAGE PROFICIENCY REQUIREMENTS)

EDUCATIONAL INFORMATION—DENTURISM RELATED

Name & Location of College/University	Diploma/Degree Course of Study	Date Commenced	Date Completed

LICENSE INFORMATION

List all jurisdictions where you are/were licensed or registered to practice denturism / dentistry

Jurisdiction	Registration/License Number	From (date)	To (date)

CONSENT FOR RELEASE OF INFORMATION

I have made an application with the College of Denturists of Ontario for a Certificate of Registration in order to engage in the practice of denturism in Ontario. The College may wish additional information in connection with my application and I have agreed to cooperate with the College to assist it in processing my application.

I therefore, hereby irrevocably authorize and direct the:

Name of Regulatory Body (Make additional copies of form if more than one Regulator)

Address

Country Post Code/ Zip Telephone No.

to provide to the College of Denturists of Ontario, at my expense, with full disclosure of any and all information you may have respecting my professional conduct, competence and capacity including providing a copy of any written information in my file pertaining to these matters and this shall be your full, final and irrevocable authority for so doing.

It is further understood and acknowledged by me that I have been advised by the College that I should obtain legal advice prior to executing this consent and that I have either done so or have had sufficient opportunity to do so prior to executing consent for release of information.

Signature of Applicant _____ Signature of Witness _____

Applicant – print name _____ Witness-print name _____

Date _____

REPORTING REQUIREMENTS

These questions apply to any jurisdiction, not just Ontario, and to any profession, not just Denturism

	Yes	No
Have you ever been found guilty of a criminal offence?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been found guilty of any other offence that might reasonably be considered relevant to your suitability to practice Denturism?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been the subject of a finding of professional misconduct, incompetence or incapacity, or similar finding in any jurisdiction regarding any profession?	<input type="checkbox"/>	<input type="checkbox"/>
Are you currently the subject of a proceeding for professional misconduct, incompetence or incapacity or similar conduct in any jurisdiction regarding any profession?	<input type="checkbox"/>	<input type="checkbox"/>
Is there any other conduct or omission that might be reasonably viewed as relevant to your practicing Denturism with decency, integrity and honesty and in accordance with the law?	<input type="checkbox"/>	<input type="checkbox"/>

Any changes to the above noted information that are initiated after submission of this application form must be reported to the College immediately.

If the answer to any of the above questions is yes, please provide full particulars here: (Use extra page if necessary)

Please attach passport photo here. Ensure that the Applicant's name is in block letters and signature is on the reverse side.

Please attach passport photo here. Ensure that the Applicant's name is in block letters and signature is on the reverse side.

Every false or misleading statement made by the applicant in this application or in any supporting documentation is cause for rejection or for revocation after a certificate of registration has been granted.

I, _____
applicant given name(s) applicant surname

Living at _____
street address city

_____, am applying for a
Province/state country

certificate of registration with the College of Denturists of Ontario for a full scope of practice within the Province of Ontario.

I understand that if I take no action on my application in any 12 month period that the College of Denturists of Ontario will deem my application to be abandoned and will close the file. I will then have to file a new application for consideration.

I commit to comply with the provisions of the *Regulated Health Professions Act, 1991*, the *Denturism Act, 1991*, the *Code* and the Regulations and Bylaws of the College of Denturists of Ontario.

I declare that all the information provided in this application is true and complete.

I authorize the College of Denturists of Ontario to verify the facts stated in this application.

Name of applicant (please print) _____ Date _____

Signature of applicant _____

=====

I attest that I have witnessed the applicant sign the application form on the line above

Name of witness (please print) _____

Date _____

Signature of witness _____

Witness address: _____
Street address City

Prov/State Post Code/Zip Country