COLLEGE OF DENTURISTS OF ONTARIO

Clinic Name Registration Application Form

Please review the Clinic Name Policy the Guide to Clinic Naming and the Clinic Name FAQ's prior to submitting your application.

Unless you are using your name as listed on the College's Public Register followed by "Denture Clinic", all practising Denturists are required to have their clinic name approved by the College of Denturists of Ontario's Executive Committee prior to registering their clinic name with Service Canada.

*This form can be filled out **electronically** or by hand.*

Section 1: Applicant's Name and Contact Information

1. a) Applicant's Information (Owner of the Clinic)

Salutation: ◯ Ms. ◯ Mrs. ◯ Mr.

Certificate of Registration #:

Last Name:

First Name:

1. b) Applicant's Mailing Address

Clinic Name:

Address:

Unit/Suite:

City:

Province:

Postal Code:

Email:

Phone:

Fax:

1. c) Partner's Information (only applicable if the applicant is opening clinic with a partner)

Partner's Full Name:

Registration No.:

Partner's Full Name:

Registration No.:

Partner's Full Name:

Registration No.:

Section 2: Clinic Name Proposal and Information

2. a) Proposed Clinic Name and Address

We recommend providing two possible clinic names.

Proposed Clinic Name:

Alternate Proposed Clinic Name:

Address: Unit/Suite:

City: Province: Postal Code:

Email:

Phone: Fax:

2. b) Clinic Type, Status, Information and Name Search

Clinic Type

- ◯ Existing Clinic
- ◯ New Clinic
- ◯ Mobile Clinic only

Current Name of Existing Clinic

Anticipated Opening Date of New Clinic

mm/dd/yyyy

Will this be your Primary Practice ◯ Yes ◯ No

I have completed a proper name search (e.g. provincial business name search, and search of the internet) to confirm the name being proposed is not already in use by a practitioner in my area. ◯ Yes ◯ No

What is the reason for the proposed clinic name(s)?

Section 3: Declaration and Signature

Applicant's Authorized Signature

By signing below, I am indicating my intention to apply for a clinic name with the College of Denturists of Ontario, and I have verified the information provided on this application to be correct.

Please note that the Executive Committee meets approximately 4 times a year.

Signature

Date (mm/dd/yyyy)

Section 4: Payment Information

Payment amount to process your application: **$25.00 + $3.25 HST = $28.25**

Method of Payment:

◯ Cheque/Money Order - made payable to the College of Denturists of Ontario

◯ Credit Card - Visa/MasterCard

If you are paying by Credit Card, please use **Form E4** **"Credit Card Payment Form"**

Section 5: Form Submission

The completed form and payment can be submitted to the College by one of the following methods:

Email: **info@denturists-cdo.com**
Subject Line: Clinic Name Application

Fax: 416-925-6332
Attn: Clinic Name Application

Mail:
Attn: Clinic Name Application
College of Denturists of Ontario
365 Bloor Street East, Suite 1606
Toronto, ON M4W 3L4

Your application will be processed when all documents and payment have been received.

For Office Use Only:

Clinic Name Approved/Not Approved: _____

Clinic Name Approved: ☐ Yes ☐ No

Date Clinic Name Approved/Not Approved: _____