College of **Dental Hygienists** of Ontario
L'Ordre des **hygiénistes dentaires** de l'Ontario
Protecting your health and your smile / Nous protégeons votre santé et votre sourire

69 Bloor Street East, Suite 300, Toronto ON M4W 1A9 www.cdho.org
Phone: 416-961-6234 Toll Free: 1-800-268-2346 Fax: 416-961-6028

Application for Clinical Competency Evaluation

For Office Use Only: Application Received: _____ Date of Clinical Evaluation: _____

Location of Clinical Evaluation: _____ Results of Clinical Evaluation: Successful ❑ Unsuccessful ❑

$1,000.00 CAD – Fee Required for Clinical Competency Evaluation

Card No. _____ Exp. Date _____

Visa—Credit ❑ Debit ❑ Prepaid ❑ **MasterCard**—Credit ❑ Prepaid ❑

Cardholder Name _____
(as it appears on the card)

Certified Cheque ❑ **OR** Money Order ❑
(payable to the CDHO in Canadian funds)

NO CASH / PERSONAL CHEQUES ACCEPTED

Contact Information

Do You Require a Left-Handed Unit? Yes ❑ No ❑

Surname: _____ **Given Names:** _____

Home Address: (Current/Actual) _____
Street Apt/Unit #

_____
City Province Postal Code

Telephone: _____ **E-mail:** _____

Dental Hygiene Education

Name of College: _____ **Location:** _____

Graduation Date: _____

Required Documentation: (Tick One)
❑ Copy of Dental Hygiene Diploma – enclosed with this form
OR ❑ Form C and transcripts – submitted directly from your college of graduation

Have you successfully passed the NDHCE? Yes ❑ No ❑ **Date** mm / dd / yyyy **No.** _____

Have you been unsuccessful on a clinical evaluation in Ontario, another province or territory?

If so, which one/s _____ **Date/s** _____

Professional Liability Insurance

Insurance Company: _____ **Policy No.:** _____

Amount of Coverage: _____ **Expiration Date:** _____

Required Documentation: ❑ Copy of Professional Liability Insurance Policy – enclosed with this form

I DECLARE THAT THE ABOVE INFORMATION IS CORRECT AND AGREE TO HAVE MY RESULTS SHARED WITH OTHER DENTAL HYGIENE REGULATORY AUTHORITIES.

_____ _____
Signature of Applicant **Date**