

## Form B - Certificate of Professional Conduct

Section 2 of this form must be completed by the regulatory/licensing body in any jurisdiction in which you have been registered as a dental hygienist or any other regulated profession.

### SECTION 1

**SURNAME**

**GIVEN NAMES**

**FORMER NAME(S)**

**REGULATORY/LICENSING BODY**

**REGULATORY BODY ADDRESS:**

Street

City

Province

Postal Code

Country

**I AUTHORIZE** \_\_\_\_\_ (Name of Regulatory/Licensing Body) to provide the information requested below and any additional information requested by the College of Dental Hygienists of Ontario in order to process my application.

\_\_\_\_\_  
**APPLICANT'S SIGNATURE**

\_\_\_\_\_  
**DATE**

### SECTION 2

To be completed by the Regulatory/Licensing Body and forwarded directly to:

**The College of Dental Hygienists of Ontario**  
175 Bloor Street East, North Tower, Suite 601  
Toronto, Ontario, Canada M4W 3R8

**NAME OF APPLICANT**

**CERTIFICATE OF REGISTRATION/LICENCE NUMBER**

**DATE OF REGISTRATION**

**DATE OF EXPIRY**

**CATEGORY OF REGISTRATION**

SECTION 2 (CONT'D)

Has the applicant ever had a finding in the nature of professional misconduct, incompetence or incapacity, or a like finding made against her or him?	Yes	No
Is the applicant currently under investigation or involved in any proceedings for conduct in the nature of professional misconduct, incompetence or incapacity or any like investigation or proceeding?	Yes	No
If the answer to either question is "Yes", please provide an explanation.		

I, \_\_\_\_\_ (Name of Registrar/Secretary), the Registrar/Secretary acting on behalf of the \_\_\_\_\_ (Name of Regulatory/Licensing Body), do hereby certify that the foregoing statements are true statements of the registration record for \_\_\_\_\_ (Name of Applicant).



\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date