

Certificate of Professional Conduct

To be completed by the individual requesting the certificate and [emailed to the CDHO](#).

SURNAME	GIVEN NAMES	FORMER NAME(S) (if applicable)	
MAILING ADDRESS:	Street	City	
	Province	Postal Code	Country
TEL.	FAX	EMAIL	
REGISTRATION NO.	NAME OF RECEIVING ORGANIZATION		
	ADDRESS		

FEE: There is a fee of \$15 for a certificate of professional conduct.

ONLINE PAYMENT

An email with payment instructions will be sent to you once your application has been approved.

AUTHORIZATION TO RELEASE INFORMATION

I authorize the College of Dental Hygienists of Ontario to release any information in its possession regarding my registration to the organization listed above. I understand that this may include information related to the following: registration history; conduct history, including complaint and disciplinary records; compliance with quality assurance program requirements; and any other information requested by the organization or otherwise relevant to my suitability to practise.

SIGNATURE

DATE

If the receiving regulatory authority requires completion of a specific form, please attach it to this authorization.