CDHO
COLLEGE OF DENTAL HYGIENISTS OF ONTARIO

Professional Verification of Medical Condition

Please note that this verification of patient illness, injury or disability must be completed by a registered health professional.

SECTION 1 (TO BE COMPLETED BY PATIENT)

I, PRINT NAME , Registration # CDHO 6-DIGIT REGISTRATION # , authorize this registered health professional to provide the below confidential information to the College of Dental Hygienists of Ontario. The College may contact this person to verify the information provided but may not request additional information without my permission.

Patient's signature:	Date: (MM/DD/YYYY)

SECTION 2 (TO BE COMPLETED BY REGISTERED HEALTH PROFESSIONAL)

The above-named patient has requested special consideration on medical grounds. The patient is authorizing you to release the information requested below. Please retain a copy of this form for your files as your office may be contacted to verify that this statement was completed in your office.

In your professional opinion, what extent does this condition have on the patient's ability to provide safe, competent dental hygiene care or to submit her/his quality assurance records for review? (It is not necessary to disclose the nature of the illness or the treatment, but it is essential to know the effect the illness and treatment had, or will have, on the patient's ability to provide safe, competent care and to participate in the Quality Assurance (QA) Program.

Have you advised this patient to make any adjustments to her/his work schedule? If so, has the patient made these adjustments?

Explain limitations, if any.

FOR THE PRESENT MEDICAL CONDITION, PLEASE INDICATE THE FOLLOWING:

On what date(s) did you see the patient?

What was the date of onset of the illness?

How long might the illness affect his/her ability to provide safe, competent care and/or participate in the QA Program?

Signature:	Name and Title (please print clearly):
Address (stamp acceptable):	Registration #:
	Telephone/Fax:

Date: (MM/DD/YYYY)