Reset

CDHO
COLLEGE OF DENTAL HYGIENISTS OF ONTARIO

Request for Certificate of Standing from CDHO

To be completed by the individual requesting the certificate and emailed to CDHO.

SURNAME	**GIVEN NAMES**	**FORMER NAME(S)** (*if applicable*)

MAILING ADDRESS:	Street		City
	Province	Postal Code	Country
TEL.	**EMAIL**		
REGISTRATION NO.	**NAME OF RECEIVING ORGANIZATION** Other (please type name) **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 request is 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.