CDHO
COLLEGE OF DENTAL HYGIENISTS OF ONTARIO

Application for the Written Assessment for Registration

FOR OFFICE USE ONLY

Application Received: _____ Date of Written Assessment: _____

Location of Clinical Evaluation: _____

Results of Clinical Evaluation: Successful Unsuccessful

$675 FOR THE FIRST ATTEMPT, OR $575 FOR SUBSEQUENT ATTEMPTS OR WHEN ALSO APPLYING FOR THE CLINICAL COMPETENCY EVALUATION

☐ I will pay online after my application is approved. I understand that failure to make prompt payment after approval may result in the cancellation of my application and the loss of my reserved spot on the assessment date.

Online payments can be made with **Visa/Visa Debit** or **MasterCard/MasterCard Debit** only. Prepaid or gift cards cannot be processed through the online banking system.

CONTACT INFORMATION

LAST NAME	**GIVEN NAMES** (FIRST, MIDDLE)		
CURRENT HOME ADDRESS:	Street		Apt/Unit #
	City	Province	Postal Code

TELEPHONE	**EMAIL**
CDHO REGISTRATION ID # (if applicable):	**PREFERRED LANGUAGE FOR WRITTEN ASSESSMENT:** English ○ French ○

COLLEGE OF DENTAL HYGIENISTS OF ONTARIO

DENTAL HYGIENE EDUCATION

NAME OF COLLEGE

LOCATION	**GRADUATION DATE**
REQUIRED DOCUMENTATION (Tick one):	○ Copy of Dental Hygiene diploma – enclosed with this form or already on file **OR** ○ Certificate of Standing and transcripts – submitted directly from your college of graduation
HAVE YOU SUCCESSFULLY PASSED THE NDHCE? Yes ○ No ○	**DATE** **NO.**

DECLARATION AND SIGNATURE

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

_____ _____

Signature of Applicant Date

July 2025