



Clinical Competency Evaluation

CONSENT FORM

NAME OF CLIENT: _____

NAME OF DENTAL HYGIENIST: _____

I, _____ understand that _____
(Name of Client) (Name of Dental Hygienist)

is participating in a Clinical Competency Evaluation for the College of Dental Hygienists of Ontario.

Having had the nature and purpose of the evaluation and the procedures to be followed explained to me, I hereby authorize the above-named dental hygienist to perform those procedures for the purpose of this Clinical Competency Evaluation. I have had the opportunity to ask questions and they have been answered to my satisfaction.

I have been advised that I can request that a copy of my record of treatment be forwarded to a healthcare provider of my choice following the evaluation.

I acknowledge that at the Clinical Competency Evaluation, I may not be deemed to be acceptable as a client by the evaluator. In that case, I will not be able to act as a client for the above-named dental hygienist. I also acknowledge that the decision of the evaluator is final.

DATED AT _____ THIS _____ DAY OF _____ 20_____

(Client's Signature)

(Dental Hygienist's Signature)