

Mandatory Reporting Form

DATE

NAME OF REPORTER

Are you a regulated health professional? Yes No

If yes, which profession?

NAME OF DENTAL HYGIENIST BEING REPORTED

RELATIONSHIP OF THE REPORTER TO THE DENTAL HYGIENIST (Check all that apply)

- | | |
|---|---|
| <input type="checkbox"/> Employer/Supervisor | <input type="checkbox"/> Health Professional Corporation Co-Director/Shareholder |
| <input type="checkbox"/> Colleague/Coworker | <input type="checkbox"/> Operator of a facility/clinic where the Dental Hygienist practises |
| <input type="checkbox"/> Business Partner/Associate | <input type="checkbox"/> Other : |

REASON FOR THE REPORT (Check all that apply)

- I believe that the Dental Hygienist has sexually abused a patient.
- I believe that the Dental Hygienist who practises at my facility is incompetent or incapacitated.
- I terminated, suspended, or restricted the privileges of the Dental Hygienist because of professional misconduct, incompetence, or incapacity.
- I dissolved my partnership, association, or Health Professional Corporation with the Dental Hygienist because of professional misconduct, incompetence, or incapacity.
- I believe that the Dental Hygienist voluntarily resigned or restricted their practice because of professional misconduct, incompetence, or incapacity, or because of an investigation into their alleged professional misconduct, incompetence, or incapacity.

FOR REPORTS OF SEXUAL ABUSE ONLY

I have the **written consent** of the patient to share their name with CDHO: Yes No

The name of a patient who may have been sexually abused may only be shared with their written consent.

Please provide an explanation of the alleged sexual abuse, professional misconduct, incompetence, or incapacity:

SIGNATURE:

For questions or further information, please contact complaints@cdho.org or 416-961-6234 ext. 237.

Please print and submit this form to:

CDHO
Attn: Conduct Department
175 Bloor Street East, North Tower, Suite 601
Toronto, Ontario M4W 3R8