



CERTIFICATE OF STANDING CONSENT FOR RELEASE OF INFORMATION

I have made application with (Name of the Regulatory Body)

for licensure/registration in order to engage in the practice of dentistry in the province/state of

I, therefore, hereby irrevocably authorize and direct CDSBC to provide to:

Name of Regulatory Body _____

Address _____

City _____ Province/State _____

Phone _____ Postal/Zip Code _____

Email _____ Contact _____

with full disclosure of any and all information CDSBC may have respecting my professional conduct, competence and capacity including providing a copy of any written information in my file pertaining to these matters and this shall be your full, final and irrevocable authority for so doing.

I understand the legal implications and approve your release of any information the above named regulatory body requests. I understand that I have the right to seek legal advice prior to signing this form.

Dentist's name – please print _____

Signature of Dentist _____

CDSBC Registration number _____ Date – M/D/Y _____

Address _____ City _____

Province/State _____ Postal Code _____

Email _____

Witness's name – please print _____

Signature of Witness _____

MAKE SURE YOU HAVE SIGNED THIS FORM.



CREDIT CARD AUTHORIZATION FORM

Dentist's name: _____

VISA Mastercard

Card number: _____ **Expiry:** _____

Certificate of Standing fee:

C\$50

Cardholder's name (please print): _____

Cardholder's signature: _____

Payment by phone and debit-credit card is not available. Your signature is required to authorize payment.

MAKE SURE YOU HAVE SIGNED THIS FORM.