College of Dental Technologists of Ontario
Ordre des Technologues Dentaires de l'Ontario

APPLICATION FOR CERTIFICATE OF AUTHORIZATION FOR A HEALTH PROFESSION CORPORATION

Date of submission of application: ____ DD ____ MM ____ YYYY

For detailed information on how to complete this form, please see the Guide to Registering and Renewing Health Profession Corporations. Please print clearly.

SECTION 1: HEALTH PROFESSION CORPORATION INFORMATION			
1a. Health Profession Corporation Name & Number			
Health Profession Corporation (HPC) Name:			
Ontario Professional Corporation Number (issued by the Ministry of Government Services):			
1b. Practice Name of the Health Profession Corporation			
Practice Name:			
1c. Contact Information for the Principal Place of Practice of the Health Profession Corporation			
Street Number & Name:			Unit/Suite:
City/Town:	Province:	Postal Code:	
Phone:	Fax:	Email:	
1d. Alternate Location #1 (if applicable)			
Street Number & Name:			Unit/Suite:
City/Town:	Province:	Postal Code:	
Phone:	Fax:	Email:	
1e. Alternate Location #2 (if applicable)			
Street Number & Name:			Unit/Suite:
City/Town:	Province:	Postal Code:	
Phone:	Fax:	Email:	
1f. Alternate Location #3 (if applicable)			
Street Number & Name:			Unit/Suite:
City/Town:	Province:	Postal Code:	
Phone:	Fax:	Email:	

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SECTION 2: SHAREHOLDER INFORMATION (use additional sheets if necessary)			
2a. Shareholder #1			
Member Name (as it appears on the Public Register):			Registration Number:
Business Address (Street Number & Name):			Unit/Suite:
City/Town:		Province:	Postal Code:
Phone:		Fax:	Email:
☐ Director	☐ Officer	Title of Office (if applicable):	
2b. Shareholder #2			
Member Name (as it appears on the Public Register):			Registration Number:
Business Address (Street Number & Name):			Unit/Suite:
City/Town:		Province:	Postal Code:
Phone:		Fax:	Email:
☐ Director	☐ Officer	Title of Office (if applicable):	
2c. Shareholder #3			
Member Name (as it appears on the Public Register):			Registration Number:
Business Address (Street Number & Name):			Unit/Suite:
City/Town:		Province:	Postal Code:
Phone:		Fax:	Email:
☐ Director	☐ Officer	Title of Office (if applicable):	
2d. Shareholder #4			
Member Name (as it appears on the Public Register):			Registration Number:
Business Address (Street Number & Name):			Unit/Suite:
City/Town:		Province:	Postal Code:
Phone:		Fax:	Email:
☐ Director	☐ Officer	Title of Office (if applicable):	

2e. Shareholder #5			
Member Name (as it appears on the Public Register):			Registration Number:
Business Address (Street Number & Name):			Unit/Suite:
City/Town:		Province:	Postal Code:
Phone:		Fax:	Email:
☐ Director	☐ Officer	Title of Office (if applicable):	
2f. Shareholder #6			
Member Name (as it appears on the Public Register):			Registration Number:
Business Address (Street Number & Name):			Unit/Suite:
City/Town:		Province:	Postal Code:
Phone:		Fax:	Email:
☐ Director	☐ Officer	Title of Office (if applicable):	

SECTION 3: PROFESSIONAL ACTIVITIES

Provide a brief description of the activities that the health profession corporation plans to carry out:

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SECTION 4: REGISTRANTS PRACTISING ON BEHALF OF THE CORPORATION	
The following Registrants will be practising on behalf of the corporation, as of the date of the application submission:	
Member Name:	Registration Number:
Member Name:	Registration Number:
Member Name:	Registration Number:
Member Name:	Registration Number:
Member Name:	Registration Number:
Member Name:	Registration Number:
Member Name:	Registration Number:
Member Name:	Registration Number:
Member Name:	Registration Number:
Member Name:	Registration Number:

SECTION 5: DECLARATION OF THE DIRECTOR

Declaration of the Director of the Health Profession Corporation

I, _____, a director of _____,
(Print Full Name of Director) (Print Name of Health Profession Corporation)
hereby certify that the following statements are true:

1) I am a Member of the College of Dental Technologists of Ontario and my Certificate of Registration is not currently revoked or suspended.
2) The corporation noted in this Application for Certificate of Authorization is incorporated and is in compliance with the *Business Corporations Act of Ontario*.
3) The corporation does not plan to carry on, and will not carry on, any business that is not the practice of dental technology or an activity related or ancillary to the practice of dental technology.
4) There has been no change in the status of the corporation since the date of the Corporation Profile Report enclosed with this Application for Certificate of Authorization.

I have personal knowledge of the declarations contained in this Application for Certificate of Authorization, and the information contained herein is complete, accurate, and true, to the best of my knowledge.

_____ _____
Signature of Director **Date of Signature**

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CHECKLIST FOR APPLICATION	
Submit the following documents for application:	
☐	Application for Certificate of Authorization of a Health Profession Corporation (this form), signed by the director
☐	Shareholder Undertaking for a Professional Corporation (signed by **each** shareholder of the corporation, including all directors)
☐	A copy of a Corporation Profile Report, issued by the Ministry of Government and Consumer Services that is dated not more than **30 days** before the application is submitted to the College
☐	A copy of the Certificate of Incorporation of the corporation issued by the Ministry of Government and Consumer Services
☐	A copy of every certificate of the corporation that has been endorsed under the *Business Corporations Act*, as of the day this application is submitted
☐	A copy of the Articles of Incorporation of the corporation
☐	Declaration by a director of the corporation signed no more than **15 days** before this application is submitted (Section 5 of this form)
☐	Application fee payment (non-refundable) is payable by credit card.

Please Note: Your application for the Certificate of Authorization will be processed when all documents have been received. When the corporation has been approved, the director will be required to submit payment of the Certificate of Authorization fee. Please refer to Schedule 5 of the College By-Laws for the current fees. Completing this application for a health profession corporation and submitting your documents does not imply, in any manner, that it is authorized by the College. The health profession corporation is not formally authorized until the Director of the corporation has received written confirmation and a Certificate of Authorization from the College.

OFFICE USE ONLY	
Date Received:	
Verified by:	
❑ Application Approved – date approved: _____	
❑ Application Denied – date denied: _____ Reason(s) denied:	
Registrar's Signature:	**Date Signed:**