



RENEWAL FORM 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 I: HEALTH PROFESSION CORPORATION INFORMATION | | |
|---|-----------|--------------|
| Ia. Health Profession Corporation Name & Number | | |
| Health Profession Corporation (HPC) Name: | | |
| Ontario Professional Corporation Number (issued by the Ministry of Government Services): | | |
| Ib. Practice Name of the Health Profession Corporation | | |
| Practice Name: | | |
| Ic. 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: |
| Id. Alternate Location #1 (if applicable) | | |
| Street Number & Name: | | Unit/Suite: |
| City/Town: | Province: | Postal Code: |
| Phone: | Fax: | Email: |
| Ie. Alternate Location #2 (if applicable) | | |
| Street Number & Name: | | Unit/Suite: |
| City/Town: | Province: | Postal Code: |
| Phone: | Fax: | Email: |
| If. Alternate Location #3 (if applicable) | | |
| Street Number & Name: | | Unit/Suite: |
| City/Town: | Province: | Postal Code: |
| Phone: | Fax: | Email: |



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: |
| <input type="checkbox"/> Director | <input type="checkbox"/> 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: |
| <input type="checkbox"/> Director | <input type="checkbox"/> 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: |
| <input type="checkbox"/> Director | <input type="checkbox"/> 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: |
| <input type="checkbox"/> Director | <input type="checkbox"/> 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: | |
| <input type="checkbox"/> Director | <input type="checkbox"/> 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: | |
| <input type="checkbox"/> Director | <input type="checkbox"/> 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 Renewal Form for Certificate of Authorization is incorporated and is in compliance with the *Business Corporations Act of Ontario*.
- 3) There has been no change in the status of the corporation since the date of the Corporation Profile Report enclosed with this Renewal Form for Certificate of Authorization.

I have personal knowledge of the declarations contained in this Renewal Form 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



CHECKLIST FOR RENEWAL

Submit the following documents for renewal:

- Renewal Form for Certificate of Authorization of a Health Profession Corporation (this form), signed by the director
- Shareholder Undertaking signed by each **new** shareholder of the corporation
- 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 every certificate of the corporation that has been endorsed under the *Business Corporations Act* since the corporation's most recent application for or renewal of the Certificate of Authorization
- A copy of the Articles of Incorporation of the corporation (only if revised after the original application for a Certificate of Authorization)
- Declaration by a director of the corporation signed no more than **15 days** before this application is submitted (Section 5 of this form)
- The Certificate of Authorization Fee is payable by credit card.

Please Note: Your renewal for the Certificate of Authorization will be processed when all documents have been received. The Certificate of Authorization for the health profession corporation is not formally renewed until the Director of the Corporation has received written confirmation 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: