AUTHORIZATION FORM

If you have been registered in more than one province, this form must be completed by all of the appropriate bodies.

SECTION 1	
I, ____, authorize (Name of Applicant) ____ to provide (Name of Regulatory/Licensing Body) the information requested below and any additional information requested by the College of Dental Technologists of Ontario. This authorization includes providing a copy of any written information in my file pertaining to these matters, in order to process my application for registration.	
Date:	Applicant's signature:
SECTION 2	
Name of Applicant:	
Certificate of Registration/License Number:	
Date of Registration:	Date of Expiry:
Class/Category of Registration:	
The applicant currently registered/licensed and in good standing: ☐ Yes ☐ No	
Has the applicant ever had a finding in the nature of professional misconduct, incompetence or incapacity, or a like finding made against her or him? ☐ Yes ☐ No Is the applicant currently under investigation or involved in any proceedings for conduct in the nature of professional misconduct, incompetency or incapacity or any like investigation or proceeding? ☐ Yes ☐ No ***(If the answer to either question is "yes", please provide a written explanation of the proceedings and any relevant documents.)***	
I, ______________________ the Registrar/Executive Director acting on behalf of the ______________________, do hereby certify that the foregoing statements are true (Name of Regulatory/Licensing Body) statements of the registration/licensure record for ______________________. (Name of Applicant)	
Date:	
Registrar/Executive Director's Signature:	

REGULATORY/LICENSING BODY TO SEND COMPLETED FORM DIRECTLY TO CDTO VIA EMAIL: registrar@cdto.ca