COLLEGE OF
DENTAL HYGIENISTS
OF MANITOBA

610-1445 Portage Ave, Winnipeg MB R3G 3P4

REGISTRATION CANCELLATION FORM

CANCELLATION BY REQUEST: Please complete if you plan on cancelling your registration with the CDHM

Current Name on Register:

_____

Street Address with City, Province, and Postal Code

_____

_____

Home Phone: _____

Cell Phone: _____

Email Address: _____

Sign and date the cancellation request below

Please cancel my registration. I understand that this request will cause my name to be removed from the Register of the Dental Hygienists Practicing or Non-practicing Register. I understand that if I re-apply for registration with the CDHM, I will be required to meet the requirements of a new applicant and I may be subject to a re-instatement fee.

This form can be emailed or mailed to the CDHM office.

Signature: _____

Date: _____
MM/DD/YY