



Verification of Licensure/ Registration

Section A: To be filled out by Applicant

Please complete this section and forward with section B to each jurisdiction you are, or have been, registered as a dental hygienist.

Surname Given Name(s)

Former Name(s) (If applicable)

Date of Birth (mm/dd/yyyy) Registrant Number

Address

City Province/State

Postal Code Country

Email Phone Number

I was Registered/Licensed with: _____

From (mm/dd/yyyy) To (mm/dd/yyyy)

Authorization

I authorize _____ to provide the information
Name of Regulatory/ Licensing Body

requested in Section B of this form and any other information requested by the College of Dental Hygienists (CDHM) in order to process my application for registration.

Signature

Date (mm/dd/yyyy)

Section B: To be completed by the Regulatory/Licensing body and forwarded directly to the CDHM with Section A.

Profession:

Dental Hygienist

License Registration Status:

Active (practicing)

Inactive (non-practicing)

Initial Date of Registration: _____
(mm/dd/yyyy)

Temporary

Conditional

Registration Expiry Date: _____
(mm/dd/yyyy)

Other

(explain): _____

- | | | |
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| 1. Has the applicant's entitlement to practice dental hygiene currently or ever been cancelled, suspended, limited, restricted, or made subject to conditions. | Yes | No |
| 2. Is the Applicant currently under investigation, review, or involved in any other proceeding that could result in their entitlement to practice the profession being cancelled, suspended, limited, restricted, or made subject to conditions. | Yes | No |
| 3. Has the applicant ever had a finding in the nature of professional misconduct, incompetency, or any like investigation or proceeding? | Yes | No |

If the answer to one or more of the preceding questions is 'Yes' please provide further information in an attached letter.

Has the applicant met all applicable continuing competency and quality assurance requirements?	Yes	No
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Has the applicant provided you with evidence of graduation (e.g. degree diploma, and/or transcript) from an accredited Dental Hygiene Program?	Yes	No
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Has the applicant provided you with evidence of holding a NDHCB Certificate?	Yes	No
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If 'Yes' please provide: NDHCE #: _____ Effective Date: _____
(mm/dd/yyyy)

Print Name: _____

Title: _____

Name of Regulatory/
Licensing Body: _____ (Seal)

Province/State/Country: _____

Signature: _____

Date: _____
(mm/dd/yyyy)