COLLEGE OF DENTAL HYGIENISTS OF MANITOBA

610-1445 Portage Ave
Winnipeg Manitoba
R3G 3P4
Phone: 204-219-2678
Email: cdhm@cdhm.info

Verification of Licensure/ Registration

<u>Section A:</u> 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 am/was Registered/Licensed with:______________________________

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

<u>Authorization</u>

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

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

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

License Registration Status:

Active (practicing)

Inactive (non-practicing)

Temporary

Conditional

Other

(explain): ____________________________

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

Has the applicant provided you with evidence of graduation (e.g. degree diploma, and/or transcript) from an accredited Dental Hygiene Program? Yes No

If 'Yes': ____
Name of Dental Hygiene Educational Institution

Year of Graduation: ___________

Has the applicant provided you with evidence of holding a NDHCB Certificate Yes No

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)