DENTAL COUNCIL

MINISTRY OF HEALTH

Request for Certificate of Good Standing

(Please Print Information Clearly)

FIRST NAME: ..... MIDDLE NAME: .....

SURNAME: ..... MALE: [] FEMALE: []

DATE OF BIRTH: ..... (DD/MM/YY)

PROFESSION: ..... REGISTRATION NO.: .....

DATE OF FIRST REGISTRATION: .....

MAILING ADDRESS: .....

.....

TELEPHONE NO.: (W) ..... (H) ..... (C) .....

EMAIL ADDRESS: .....

FORWARDING ADDRESS FOR CERTIFICATE OF GOODSTANDING:

.....

.....

.....

BASIC QUALIFICATION: ..... DATE OBTAINED: .....

UNIVERSITY / COLLEGE: .....

SPECIALIST QUALIFICATION: ..... DATE OBTAINED: .....

UNIVERSITY / COLLEGE: .....

SIGNATURE: ..... DATE: .....