Consent for Release of Information

College of Dental Surgeons of Alberta

Please complete this form and return it to:
College of Dental Surgeons of Alberta
Attention: Registration Department
Suite 402, 7609 – 109 Street
Edmonton, Alberta T6G 1C3

I, Dr. _____
(FIRST NAME / LAST NAME)

have made application with the College of Dental Surgeons of Alberta for a Certificate of
(RECEIVING JURISDICTION)
Registration/License in order to engage in the practice of dentistry in Alberta.

The College of Dental Surgeons of Alberta, as part of its registration/licensure process, requires that it's Certificate of Standing form be completed by every jurisdiction in which I was licensed/registered and/or engaged in the practice of dentistry or applied for registration. As most jurisdictions require my consent to release the requested information, I am hereby signing my permission to and irrevocably authorize and direct the

_____
(ORIGINATING JURISDICTION)

to provide, at my expense, any information requested by the College of Dental Surgeons of Alberta. I understand and accept that this means providing full disclosure of any and all information that was obtained while performing this adjudicative function. This can include but is not limited to, amongst other matters, information whether deemed public or non-public, undertakings or agreements, verbal or written between me and the

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(ORIGINATING JURISDICTION)

about complaints, investigations, inspections, professional conduct, competence, fitness and capacity, past and present, and any and all applications to register to practice dentistry including providing a copy of any written information in my

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(ORIGINATING JURISDICTION)

file pertaining to these matters and this shall be your full final and irrevocable authority for so doing.

Moreover, the College of Dental Surgeons of Alberta may wish further information or clarification respecting information it receives from the

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(ORIGINATING JURISDICTION)

in connection with my application and I hereby further authorize the

_____
(ORIGINATING JURISDICTION)

to assist and co-operate with the College of Dental Surgeons of Alberta in providing any other/ additional information it might request or that the

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(ORIGINATING JURISDICTION)

deems to be relevant to my application in Alberta.

It is understood and acknowledged by me that I have been advised by the College of Dental Surgeons of Alberta that I might wish to obtain legal advice prior to executing this consent and that I have either done so or have had sufficient opportunity to do so prior to executing this consent for release of information. I am signing this document of my own free will, voluntarily and without coercion, having read it and having understood it.

IN WITNESS WHEREOF I have duly executed this release form this _____ day of _____, 20____.

_____
Printed Name of Applicant

_____
Signature of Applicant

_____
Printed Name of Witness

_____
Signature of Witness