

Mailing Address  
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Vancouver, BC V6J 5C6

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## RETIREMENT/RESIGNATION FROM THE BC COLLEGE OF ORAL HEALTH PROFESSIONALS

I hereby retire/resign as a registrant of the BC College of Oral Health Professionals (BCCOHP).

I understand that:

1. Once my retirement/resignation takes effect, my registration expires and my authority to practise dentistry in British Columbia immediately ceases.
2. After I retire/resign, if I then wish to resume the practice of dentistry in British Columbia, I must apply to BCCOHP for reinstatement of my registration and I must comply with all the standards and qualifications for registration in effect at that time. The standards and qualifications for registration are subject to change without notice, and I may not be compliant with the standards and qualifications in effect now or in the future.
3. I must contact my malpractice/liability insurance provider to inform them of my retirement/resignation.
4. I have notified my patients that I am retiring/resigning from dentistry and those patients with planned or partially completed care, or those in need of monitoring of a dental condition have had arrangements made for them as to who may provide this care.
5. If I have participated in the Controlled Prescription Program and possess duplicate prescription pads, I will return all partially and fully unused pads to BCCOHP for them to be destroyed.

Name of Resigning Dentist \_\_\_\_\_ BCCOHP Registration Number \_\_\_\_\_

Signature \_\_\_\_\_ Date – M/D/Y \_\_\_\_\_

My retirement/resignation from BCCOHP is effective as of – M/D/Y \_\_\_\_\_

**Note: your request cannot be backdated.**

Dental Records	
My patient records have been transferred to: <input type="checkbox"/> another dentist <input type="checkbox"/> a secure file-storage facility <input type="checkbox"/> other	Location of patient records:

**Please return this form by:**      **Mail:** ATTN: Registration  
110 - 1765 8th Ave W  
Vancouver, BC, V6J 5C6      **Email:** registration@oralhealthbc.ca

MAKE SURE YOU HAVE SIGNED THIS FORM.