

Mailing Address
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RESIGNATION FROM THE BC COLLEGE OF ORAL HEALTH PROFESSIONALS

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

I understand that:

1. Once my resignation takes effect, my licence expires and my authority to practise in British Columbia immediately ceases.
2. After I resign, if I then wish to resume practice in British Columbia, I must apply for practising licence with BCCOHP and I must comply with all the standards and qualifications for licence in effect at that time. The standards and qualifications for licence 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 resignation.
4. I have notified my patients that I am resigning from practice 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. (Dentists only) 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 Licensee _____ BCCOHP Licensee Number _____

Signature _____ **Date – M/D/Y** _____

My 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.