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## CERTIFICATE OF STANDING – CONSENT FOR RELEASE OF INFORMATION

I have made application with \_\_\_\_\_  
for the purpose of \_\_\_\_\_.

I hereby, irrevocably authorize and direct BCCOHP to provide the following organization with information with respect to my current standing with BCCOHP.

Name of Organization \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ Province/State \_\_\_\_\_  
Phone \_\_\_\_\_ Postal Code \_\_\_\_\_  
Email \_\_\_\_\_ Contact \_\_\_\_\_

I consent to the release of information with full disclosure of any and all information BCCOHP may have respecting my professional conduct, competence and capacity including providing a copy of any written information in my file pertaining to these matters and this shall be your full, final and irrevocable authority for so doing.

**Licensee Surname** – please print \_\_\_\_\_  
Given Name(s) \_\_\_\_\_  
Former Name(s) (if applicable) \_\_\_\_\_

**Signature of Licensee** \_\_\_\_\_ Date – M/D/Y \_\_\_\_\_

BCCOHP Licence number \_\_\_\_\_ Date of Birth (M/D/Y) \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_  
Province/State \_\_\_\_\_ Postal Code \_\_\_\_\_  
Email \_\_\_\_\_ Phone \_\_\_\_\_

**Witness's name** – please print \_\_\_\_\_

**Signature of Witness** \_\_\_\_\_ Date – M/D/Y \_\_\_\_\_

<b>Fees</b> <b>Certificate of Standing</b> _____ C\$79	Once your request is ready to be finalized, you will receive an email invoice to pay the fee online.
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**Please submit your completed consent form by e-mail to: [registration@oralhealthbc.ca](mailto:registration@oralhealthbc.ca)**

**MAKE SURE YOU AND YOUR WITNESS HAVE SIGNED THIS FORM.**