Consent for Release of Information

Please complete this form and return it to:
College of Dental Surgeons of Saskatchewan
201 1st Ave S
1202 The Tower at Midtown
Saskatoon, SK S7K 1J5

Email: cdss@saskdentists.com

I, Dr. ____ have applied for licensure with The College of Dental Surgeons of Saskatchewan. I am hereby signing my permission to irrevocably authorize and direct the College of Dental Surgeons of Saskatchewan (CDSS) to provide, my name and clinic information to their public database.

It is understood and acknowledged by me that I have been advised by the College of Dental Surgeons of Saskatchewan that I may 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 understood it fully.

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)