



Consent for Release of Information

Please complete this form and return it to your originating jurisdiction and send a copy to:

**College of Dental Surgeons of Saskatchewan
201 1st Ave S**

**1202 The Tower at Midtown
Saskatoon, SK S7K 1J5**

- mail: cdss@saskdentists.com

I, Dr. _____ have an application with the College of Dental Surgeons
(FIRST NAME/LAST NAME)

of Saskatchewan for a Certificate of Registration/License in order to engage in the practice of dentistry in Saskatchewan.

I am hereby signing my permission to irrevocably authorize and direct the _____
(NAME OF ORIGINATING JURISDICTION)

to provide, at my expense, any information requested by the College of Dental Surgeons of Saskatchewan.

I understand and accept that this means full disclosure of any and all information you have that was obtained while performing your 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 myself and the _____.
(NAME OF ORIGINATING JURISDICTION)

Complaints, investigations, inspections, my professional conduct, competence, fitness and capacity, past and present, including providing a copy of any written information in my _____ file
(NAME OF ORIGINATING JURISDICTION)

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

Moreover, the College of Dental Surgeons of Saskatchewan may wish further information or clarification respecting information it receives from the College of Dental Surgeons of Saskatchewan in connection with my application. I hereby further authorize the _____ to assist and co-operate with the College of Dental
(NAME OF ORIGINATING JURISDICTION)

Surgeons of Saskatchewan in providing any additional information it might request or that the _____ might deem relevant to my application in Saskatchewan.
(NAME OF ORIGINATING JURISDICTION)

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)