

ADVICE OF CHANGE OF NAME ON THE DENTAL COUNCIL REGISTER

Personal Details	
Current name on Register	
New name on Register	
Date of Birth (to verify identity)	
Dental Council Registration Number	
Please tick the appropriate box below to indicate the reason for the name change, and attach the necessary supporting documentation:	
<input type="checkbox"/> Marriage <input type="checkbox"/> Deed Poll <input type="checkbox"/> Common Use <input type="checkbox"/> Other (explain)	

Address Details		
Postal Address (Can be a street address or PO Box)	Practice Address	Residential Address
Phone:	Phone:	Phone
Mobile:	Mobile:	Mobile:
Fax:	Fax:	Fax:
Email:	Email:	Email:

Dental Register Information
Your address, phone, fax and email details can only be included in the published Public Register if you agree.
Which address would you like published on the Public Register? <i>(select only one)</i>
<input type="checkbox"/> None <input type="checkbox"/> Postal or <input type="checkbox"/> Practice or <input type="checkbox"/> Residential
Which contact details, pertaining to the address chosen above, would you like published on the Public Register?
<input type="checkbox"/> None <input type="checkbox"/> All <input type="checkbox"/> Email and/or <input type="checkbox"/> Phone and/or <input type="checkbox"/> Fax

Signed: _____ Date: _____

Please return this completed form by mail, email or fax to:

The Dental Council
 PO Box 10-448
 Wellington
 New Zealand
 Fax +64 4 4991668