APPLICATION FOR CERTIFICATE OF GOOD STANDING

APRIL 2018

Personal details	
Given names	Family name
Other names	
Date of birth	
Registration number	

Contact details
Please specify the address for the certificate of good standing to be sent to:
Phone
Mobile
Fax
Email

Third party information request

☑ I consent to the Dental Council seeking information from the Health and Disability Commissioner (HDC) pertaining to any investigations that the HDC may have about me, and to the HDC providing any information to the Dental Council.

Signed _____ Date _____

Payment

☐ Cheque (must be payable to the Dental Council and must be drawn on a New Zealand trading bank)

☐ Credit card (provide details below)

Type of card	**VISA / MASTERCARD (ONLY)**
Name on card	
Card number	☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐☐
Expiry date	
Amount NZ$	☐ $ 109.22
Cardholder signature	

Please return this completed form by mail or fax, with the correct fee, as above, to:

Dental Council
PO Box 10-448
Wellington 6143
New Zealand
Fax +64 4 499 1668