APPLICATION FOR REPLACEMENT CERTIFICATE

APRIL 2018

Personal details	
Given names	Family name
Other names	Title
Date of birth (to verify identity)	
Registration number	

Replacement certificate required

- ☐ Registration certificate
- ☐ Certificate of good standing
- ☐ Annual practising certificate

Address details
Street name & no.
Suburb
Town/city
Country
Postcode

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	
Expiry date	
Card number	
Amount NZ$	☐ $ 109.22
Cardholder signature	

Signed: ______________________________ Date: ______________________________

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

Dental Council
PO Box 10-448
Wellington 6143
New Zealand
Fax +64 4 499 1668
Email inquiries@dcnz.org.nz