FORM D2

CHANGE OF ADDRESS ON THE DENTAL COUNCIL REGISTER

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

Old address details		
Postal address (Can be a street address or PO Box)	**Practice address**	**Residential address**
Phone: **Mobile:** **Fax:** **Email:**	**Phone:** **Mobile:** **Fax:** **Email:**	**Phone** **Mobile:** **Fax:** **Email:**

New address details		
Postal address (Can be a street address or PO Box)	**Practice address**	**Residential address**
Phone: **Mobile:** **Fax:** **Email:**	**Phone:** **Mobile:** **Fax:** **Email:**	**Phone** **Mobile:** **Fax:** **Email:**

Dental register information
Your address, phone, fax and email details can only be included in the public register if you agree.

Which address would you like published on the public register? *(select only one)*
☐ *None* ☐ *Postal or* ☐ *Practice or* ☐ *Residential*

Which contact details, pertaining to the address chosen above, would you like published on the public register?
☐ *None* ☐ *All* ☐ *Email and/or* ☐ *Phone and/or* ☐ *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