FORM D3

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 certified copies** of the necessary supporting documentation (note we need physical copies of these documents—you cannot submit this form by email or fax):

☐ Marriage ☐ Deed Poll ☐ Common Use ☐ Other (explain)

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 published 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 to:

The Dental Council
PO Box 10-448
Wellington
New Zealand