

APPLICATION FOR CERTIFICATE OF GOOD STANDING

MARCH 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	<input type="text"/>	<input type="text"/>
Expiry date		
	Fee payable until 31 March 2018	Fee payable after 1 April 2018
Amount NZ\$	<input type="checkbox"/> \$ 107.08	<input type="checkbox"/> \$ 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

March 2018