

DENTAL COUNCIL

AN CHOMHAIRLE FIACLÓIREACHTA

57 Merrion Square, Dublin 2, Telephone (01) 6762069, 6762226

FORM OF APPLICATION FOR THE RESTORATION OF A NAME TO THE REGISTER OF DENTAL HYGIENISTS

1. Applicants name in full _____
(BLOCK CAPITALS)

Place of Birth _____ Date of Birth _____

2. Address of inclusion in the Register Address for correspondence if different

_____	_____
_____	_____
_____	_____
_____	_____

3. Qualification held by the applicant which confers entitlement to registration in the Register of Dental Hygienists.

QUALIFICATION _____

GRANTING AUTHORITY _____ *Date Granted* _____

Documents submitted as evidence of lawful possession of the qualification (s).

4. I declare that the foregoing particulars in respect of my application are correct.

Signed _____ Date _____