

**AN CHOMHAIRLE FIACLÓIREACHTA
DENTAL COUNCIL**

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

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| FOR OFFICE USE ONLY | Registration Number; | |
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APPLICATION FORM FOR THE REGISTER OF CLINICAL DENTAL TECHNICIANS

Registration Details

(Please complete in BLOCK letters)

Applicant's name in full _____

Nationality _____ Date of birth _____

Place of birth _____

Address of inclusion in the Register _____

(Please note that you are required to supply an address for inclusion in the Register. The Register is public information and, therefore, you may want your practice address listed)

Email address _____

Your email address will be used to contact you throughout the registration process

Qualification

List the qualification you hold which confers entitlement to registration in the Register.

Title of qualification _____

Granting Authority/ University _____

Date Granted _____

I declare that the foregoing particulars are correct and that I have not been previously registered in the Register of Clinical Dental Technicians.

Signed _____ Date _____

It is an offence for a person to make a false declaration for the purpose of obtaining registration. Any person who furnishes or attempts to furnish fraudulent or altered documents/certificates may be prosecuted.