AN CHOMHAIRLE FIACLÓIREACHTA
DENTAL COUNCIL

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

FOR OFFICE USE ONLY	Registration Number;	

APPLICATION FORM FOR THE REGISTER OF ORTHODONTIC THERAPISTS

Registration Details
(Please complete in BLOCK letters)

Applicant's name in full ____

Date of Birth _______ Nationality __________ Place of Birth (Country) ___________

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 _________

Details of clinical training undertaken as part of the above qualification

Name of supervising Orthodontist ______________________________________

Address of Practice ____

____

I declare that the foregoing particulars are correct and that I have not been previously registered in the Register of Orthodontic Therapists.

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.