DENTAL COUNCIL

AN CHOMHAIRLE FIACLÓIREACHTA

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

FORM OF APPLICATION FOR REGISTRATION IN THE REGISTER OF DENTAL HYGIENISTS

Registration Details
(please complete in BLOCK letters)

Registration No
(for office use only)

1. Applicant's name in full _____

Place of Birth _____ Date of Birth _____

2. Address of inclusion in the Register

_____

_____

_____

Email address; _____

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 _____