**DENTAL COUNCIL (AN CHOMHAIRLE FIACLÓIREACHTA)**

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

**FORM OF APPLICATION FOR REGISTRATION IN THE REGISTER OF ORTHODONTIC THERAPISTS**

**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 Orthodontic Therapists.

Qualification _____

Granting Authority _____

Date Granted _____

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

_____

_____

**4.** Name of supervising Orthodontist and address of practice where the clinical training was undertaken as part of qualification listed in Question 3 (above).

_____

_____

_____

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

Signed _____ Date _____