DENTAL COUNCIL

AN CHOMHAIRLE FIACLOIREACHTA

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

Restoration Details
(please complete in BLOCK letters)

Registration No
(for office use only)

I, the undersigned, (FULL NAME IN **BLOCK** LETTERS)

________________________________of (address in full) __________________________

____

do declare as follows:-

1. I am the person originally registered as ____________________________________

with the qualification or description of ____________________________________

and hereby apply for restoration of my name to the Register of Dentists.

2. **Employment Records** (from date of resignation from the Register up to date)

Grade or Title of post if relevant	Dates From To	Type of Dental Practice and Location

Signed: ____________________________ **Date**: _________________