DENTIST - FORM A

AUTHORISATION FOR RELEASE OF INFORMATION

To: _____
Name of University

To Whom It May Concern

I, _____(IC or Passport No._____)
Name of dentist

with enrolment number _____ give my consent to the

_____ to release my enrolment
Name of University

status from _____to _____ to The Singapore Dental Council
dd/mm/yyyy dd/mm/yyyy

for the purpose of verification.

_____ _____
Signature Date