

DENTIST – FORM B

AUTHORISATION FOR RELEASE OF INFORMATION

To: _____
Name of Licensing Authority

To Whom It May Concern

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

with registration number _____ give my consent to the

_____ to release my registration
Name of Licensing Authority

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

for the purpose of verification.

Signature

Date