ORAL HEALTH THERAPIST – FORM A

AUTHORISATION FOR RELEASE OF INFORMATION

To: ____

Name of Institution

To Whom It May Concern

I, ____ with enrolment number

Name of oral health therapist

________________give my consent to the ____________________________________

Name of Institution

to release my enrolment status as student from _____________ to __________________

dd/mm/yyyy dd/mm/yyyy

to the Singapore Dental Council for the purpose of verification of identity.

_______________________________ _______________

Signature Date