ORAL HEALTH THERAPIST – FORM B

AUTHORISATION FOR RELEASE OF INFORMATION

To: ____
Name of Licensing Authority

To Whom It May Concern

I, ____ with registration number
Name of oral health therapist

_________________give my consent to the _______________________________________
Name of Licensing Authority

to release my registration status as oral health therapist from _________________to
dd/mm/yyyy

______________________ to The Singapore Dental Council for the purpose of verification of
dd/mm/yyyy

identity.

_________________________________ Signature

________________ Date