



Royal College of  
Dental Surgeons of Ontario

*Ensuring Continued Trust*

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# Health Profession Corporation Name Pre-approval Form

PROPOSED HEALTH PROFESSION CORPORATION NAME:	
PROPOSED NAME (PLEASE PRINT):	

I WOULD LIKE THE COLLEGE'S REPLY TO BE FORWARDED TO:		
NAME OF DENTIST(S) FORMING CORPORATION (PLEASE PRINT):	RCDSO REGISTRATION NUMBER(S):	
ADDRESS (STREET):		
CITY:	PROVINCE:	POSTAL CODE:
TELEPHONE:	FAX:	

Please print, complete, and return to the College by fax or mail.

*Mail*

**Royal College of Dental Surgeons of Ontario**

Registration  
6 Crescent Road  
Toronto ON M4W 1T1

*Fax*

416-922-1507  
Attention: Registration