



Royal College of  
Dental Surgeons of Ontario

*Ensuring Continued Trust*

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# Health Profession Corporation Name Pre-approval Form

<b>PROPOSED HEALTH PROFESSION CORPORATION NAME:</b>
PROPOSED NAME (PLEASE PRINT):

<b>I WOULD LIKE THE COLLEGE'S REPLY TO BE FORWARDED TO:</b>		
NAME OF DENTIST(S) FORMING CORPORATION (PLEASE PRINT):		
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*

416-961-5814  
Attention: Registration