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CLINICAL COMPETENCY EVALUATION

CONSENT FORM

NAME OF CLIENT: _____

NAME OF CANDIDATE: _____

I, _____ understand that _____
(Name of Client) (Name of Candidate)

is a candidate for the certificate of registration clinical competency evaluation of the College of Dental Hygienists of Ontario.

Having had the nature and purpose of the evaluation and the procedures to be followed explained to me, I hereby authorize the above named candidate to perform those procedures for the purpose of this clinical competency evaluation. I have had the opportunity to ask questions and they have been answered to my satisfaction.

I have been advised that dental hygiene treatment will **NOT** be completed today and I am advised to seek completion elsewhere.

I acknowledge that at the clinical evaluation, I may not be deemed to be acceptable as a client by the evaluators. In that case, I will not be able to act as a client for the above named candidate. I also acknowledge that the decision of the evaluators is final.

DATED AT _____ THIS _____ DAY OF _____ 20_____

(Client's Signature)

(Candidate's Signature)