

**CERTIFICATE OF REGISTRATION  
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 him/her to perform those procedures.

DATED AT \_\_\_\_\_ THIS \_\_\_\_\_ DAY OF \_\_\_\_\_ 2008

(I have also been informed that I may contact GBC DH Clinic reception for completion of treatment for a fee.)

\_\_\_\_\_  
(Client's Signature)

\_\_\_\_\_  
(Candidate's Signature)