College of Alberta Dental Assistants

Verification of Standing Request and Consent for Release of Information

We will issue your Verification of Standing within 10 business days. We will send it directly to the organization you indicate.

Personal Information

First Name ______________________________ Registration # ______________

Last Name ____

Mailing Address ____

City/Province/Country ______________________________ Postal Code ______________

Primary Phone ______________________ Alternate Phone ______________________

E-mail ____

I am requesting that Verification of Standing be submitted on my behalf to:

Organization ____

Mailing Address ____

City/Province/Country ______________________________ Postal/Zip Code ______________

Contact Person ____

Phone ______________________ Fax ______________________

E-mail ____

Consent

We provide the applicant's Regulatory Information in Verification of Standing such as:

- name and registration number
- current status
- registration/membership history with the College (type and dates of statuses held)
- authorized practice
- continuing competence compliance
- discipline proceedings
- any other information that may be requested by the recipient

I (print name) ______________________ hereby provide irrevocable consent to the College of Alberta Dental Assistants to release Regulatory Information about myself to the recipient specified in my above request.

Signed ______________________ ______________________

Applicant's Signature Date (MM/DD/YYYY)

Fee and Payment Information

Payment for (applicant's name) ____ Registration #____________

FEE $26.25

PAYMENT METHOD ☐ MasterCard or ☐ VISA We must have the **Cardholder's** signature.

I hereby authorize **College of Alberta Dental Assistants** *to debit my credit card account.*

|_|_|_|_| |_|_|_|_| |_|_|_|_| |_|_|_|_| |_|_| |_|_|_|_| |_|_|_|

Card Number Expiry Date (MM/YYYY) CVV# (from back of card)

______________________________ ______________________________

Cardholder Name Cardholder Signature

If cardholder is other than applicant, provide cardholder mailing address and phone number:

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The Fee is **non-refundable**. Fees are subject to change at any time.

Office Use Only
Registration #
____
☐ 3rd party
Pmt Date
____

Submit Your Verification of Standing Request

Submit your request to us by mail, courier or in person to:

College of Alberta Dental Assistants
166-14315 118 Ave NW
Edmonton AB T5L 4S6

We don't accept requests by fax or email.

Questions? Need help?
Email *contact@abrda.ca* or call 780-486-2526