Verification of Standing Request and Consent for Release of Information

College of Alberta Dental Assistants

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)

166-14315 118 Ave NW, Edmonton, AB T5L 4S6 **P** 780-486-2526 **TF** 1-800-355-8940 **W** abrda.ca

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:

____

____

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