PROFESSIONAL LIABILITY PROGRAM

ROYAL COLLEGE OF DENTAL SURGEONS OF ONTARIO

A Program of the Royal College of Dental Surgeons of Ontario
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REQUEST FOR CONFIRMATION OF MALPRACTICE PROTECTION

FULL NAME: _____ _____
(First) (Last)

REGISTRATION NUMBER: _____

ADDITIONAL INSTRUCTIONS

SEND CONFIRMATION LETTER VIA:

E-mail / Fax / Mail to

01/15_3810