



ASSOCIATION of CANADIAN
FACULTIES of DENTISTRY



L'ASSOCIATION des FACULTÉS
DENTAIREs du CANADA

RELEASE FORM

For the purpose of participating in the National Dental Examining Board of Canada's (NDEB) Equivalency Process, I,

(Given Name) (Family Name) (ACFD ID number)

authorize the Association of Canadian Faculties of Dentistry (ACFD) to forward my original documents to the NDEB.

Candidate's Signature: _____ Date: _____

This form must be submitted by mail or fax (613-236-8386) to the office of the Association of Canadian Faculties of Dentistry prior to the release of any information.

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