FORM D1

APPLICATION FOR CERTIFICATE OF GOOD STANDING

Personal Details	
Given names	Family name
Other names	
Date of Birth	
Registration Number	

Contact Details
Please specify the address for the Certificate of Good Standing to be sent to:
Phone
Mobile
Fax
Email

Signed _____ Date _____

Payment

☐ Cheque (must be payable to the Dental Council and must be drawn on a New Zealand trading bank)

☐ Credit card (provide details below)

Type of Card	**VISA / MASTERCARD (ONLY)**
Name on Card	
Expiry date	
Card number	☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐☐
Amount **NZ$**	**NZ$107.33**
Signature	

Please return this completed form by mail or fax, with the correct fee, as above, to:

The Dental Council
PO Box 10-448
Wellington
New Zealand
Fax +64 4 4991668