ASSOCIATION of CANADIAN FACULTIES of DENTISTRY | L'ASSOCIATION des FACULTÉS DENTAIRES du CANADA

RELEASE FORM

I, _____ _____
(Given Name) (Family Name)

(ACFD ID number) _____

request that ACFD return all of the original documents I have provided to participate in the Eligibility Examination.

Please mail the documents to the following address:

(ACFD will not forward documents to another organization)

_____

_____

_____

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**Documents will be sent by regular mail only.*

I understand that it will take 3 – 4 weeks for the ACFD to process this request, and that the ACFD's application requirements for the Eligibility Examination are not the same as the requirements to participate in the NDEB Equivalency Process.

Candidate's Signature: _____ Date: _____

This form must be submitted to the office of the Association of Canadian Faculties of Dentistry by fax, 604-822-4532, prior to the release of any information.