



Mandatory Report

This form is for employers, facility operators or health professionals (including registered Denturists, applicants, students and interns) who wish to report a concern about the behaviour of a registered Denturist, the specifics of which are outlined below. If you wish to report a concern that falls outside these specific concerns outlined below please email complaints@denturists-cdo.com.

*This form can be filled out **electronically** or by hand.*

Section 1: Type of Concern

(Please check all applicable boxes):

Individual Health Professionals:

Registered Denturist identified below has sexually abused a patient

Facility Operators:

Registered Denturists identified below has sexual abused a patient

Registered Denturists identified below is incompetent

Registered Denturists identified below is incapacitated

Employers:

Termination, suspension, or revocation of privileges of a a registered Denturist for reasons of:

professional misconduct

incompetence

incapacity

An intention to terminate, suspend or revoke privileges of a registered Denturist, but the employee voluntarily relinquished privileges or resigned beforehand. For reasons of:

professional misconduct

incompetence

incapacity

Section 2: Reporting Information

2.a) Denturist or Other Health Professional Submitting the Report

Salutation: Ms. Mrs. Mr.

Registration #:

Full Name:

Profession:

Business Name:

Business Address:

Unit/Suite:

City:

Province:

Postal Code:

Email:

Phone:



2.b) Facility Operators & Employer Information (if applicable)

Name of Facility:

Mailing Address:

Unit/Suite:

City:

Province:

Postal Code:

Name of Contact:

Position:

Email:

Phone:

Type of Setting:

Denturist

Clinic Dental

Office Other

2.c) Registered Denturist being Reported

Full Name:

Registration #:

Address
(if known):

Unit/Suite:

City:

Province:

Postal Code:

Member's Role:

Denturist

Owner/Associate

Other

2.d) For Facility Operators and Employers only

Date registered Denturist was Hired:

[mm/dd/yyyy]

Date of Termination or Resignation:

[mm/dd/yyyy]

Employment Status

Full-Time

Part-Time

Casual



Section 4: Reporting Events

Describe the Event(s) that led to this Report (who, what where, when and why) in chronological order starting with the most recent:

Date:	Incident/Event:	Consequences to the Patient:	Member's Response/Explanation:	Employer Action:
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mm/dd/yyyy

Date:	Incident/Event:	Consequences to the Patient:	Member's Response/Explanation:	Employer Action:
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mm/dd/yyyy

Date:	Incident/Event:	Consequences to the Patient:	Member's Response/Explanation:	Employer Action:
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mm/dd/yyyy



Section 5: Other Comments

Please include any other additional comments regarding this Report:

Section 6: Signature

By signing below, I have verified the above information to be correct.

Signature

Date (mm/dd/yyyy)

Section 7: Form Submission

The completed form can be submitted to the CDO by one of the following methods:

Email: complaints@denturists-cdo.com

Subject Line: Mandatory-Reporting

Fax: 416-925-6332

Attn: Mandatory-Reporting

Mail:

Attn: Mandatory-Reporting

College of Denturists of Ontario

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