COLLEGE OF DENTURISTS OF ONTARIO

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 indentified 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:

Postion:

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:
mm/dd/yyyy				

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

Date:	Incident/Event:	Consequences to the Patient:	Member's Response/Explanation:	Employer Action:
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
365 Bloor Street East, Suite 1606
Toronto, ON M4W 3L4