

What are your expectations? (required)

AUTHORIZATION TO PROCEED:

I authorize the Saskatchewan Dental Therapists Association:

- to notify the dental therapist of the aforementioned allegations;
- to release my name to the dental therapist as required; and
- meet the requirements of full disclosure.

Complainant Signature

Date

AUTHORIZATION TO RELEASE INFORMATION:

I authorize the release of the aforementioned information and any supporting dental/medical records that I may have provided to:

- The Professional Conduct Committee of the Saskatchewan Dental Therapists Association;
- The Discipline Committee of the Saskatchewan Dental Therapists Association;
- The President of the Association and the Minister of Justice where the Professional Conduct Committee determines that a Criminal Act has occurred;
- The College of Dental Surgeons of Saskatchewan where a subsequent investigation by the College is deemed appropriate by the Saskatchewan Dental Therapists Association.

Complainant Signature

Date

The more information you can provide, the easier it will be for the Saskatchewan Dental Therapists Association to look into your complaint. If you need assistance and would like to talk to someone before filing a complaint contact:

Saskatchewan Dental Therapists Association
Executive Director
PO Box 25056
RPO River Heights
Saskatoon SK S7K 8B7
Phone: (306) 280-5163
Email: **contact@sdta.ca**