



College of Denturists of British Columbia
101 – 309 Sixth Street
New Westminster, BC V3L 3A7
Tel: 604-515-0533 Fax: 604-515-0534

Form 1

CERTIFICATION OF ELECTION

As Registrar of the College of Denturists of British Columbia, I hereby certify that

_____ of _____
(registrant's name) *(address)*

in the city of _____, Province of British Columbia, has been elected as a member of the board of the College in accordance with the *Health Professions Act* and the bylaws of the College.

The term of office of _____ as a member of the board of the College will commence April 1, _____ and terminate April 1, _____.
(year) *(year)*

GIVEN under the seal of the College at New Westminster, British Columbia, this _____ day of _____, _____.
(month) *(year)*

Registrar