I wish to confirm that my dental school is prepared to participate in the *SEAADE Peer Review & Consultation Program* and host a visit

Submitted on behalf of the

Institution____

Name of the **Head** of Dental School	(last name) (first name)
Official title used in the organisation	
Full legal name of the Dental School And Postal Address	
Phone *(include country and area codes)*	
Fax *(include country and area codes)*	
E-mail	
SEAADE Institutional Member	□ Yes, since ………………………….. □ No
Name of Contact Person in School (responsible for all arrangements)	(last name) (first name)
	E-mail
	Tel: (country code) – (city code) – (phone number)
Suggested date or dates when the visit would be most suitable	

Please return the completed form to:

Professor Dr. Toh Chooi Gait
Chairman, SEAADE Peer Review & Consultation Committee,
South East Asia Association for Dental Education
c/o Department of Conservative Dentistry,
Faculty of Dentistry,
University of Malaya,
50603 Kuala Lumpur,
MALAYSIA.
Tel: 6-03-7967 4547 or Fax: 6-03-7967 4533

For further information please e-mail to: tohcg@um.edu.my