New Volunteer DDS/DMD/ RDH/RDA Application Date:_____

Name: _____List all names used

Social Security Number::_____ Have you ever been known by any other name? (i.e., maiden name, middle name, other married name, etc.) Y or N List names: _____

CA License No. *: _____ D E A No. *: _____ Other / ADA #_____

Professional Liability Insurance* Carrier: _____(CPR) Certification * expiration date:_____
(Minimum $1MM per occurrence / $3MM aggregate required)

Have you ever been convicted of or pleaded guilty or nolo contendere (no contest) of any violation of the California Dental Practice Act? Yes___ No ___ (If yes, please attach separate sheet with explanation)

Have you ever been convicted of any crime materially related to practice of dentistry? Yes___ No___(If yes, attach explanation)

Has your license to practice dentistry ever been suspended or revoked? Yes___ No___ (If yes, attach explanation)

Personal Preference for Contact: Personal Cell:_____ Office Phone:_____

Preferred email address: _____ Emergency Contact & Ph #: _____

Home Address: _____ Circle preferred address – home or office?

Home Phone:_____ Mobile Phone: _____email:_____

Health Examination Policy: Employees and/or regular volunteers will have a health examination within six months prior to starting work at the Kids' Community Clinic of Burbank, or within 15 days after they begin seeing patients. Annual health exams are required. The report, signed by the practitioner, shall indicate that the person is able to perform assigned duties and that a health condition that would create a hazard for the volunteer, fellow volunteer, patient or visitors does not exist. The examination shall include a medical history, physical evaluation, and TB skin test. Positive reaction to the skin test shall be followed by a chest x-ray, and an annual review of the symptoms by a physician. Evidence of tuberculosis screening within 12 months prior to working at the clinic shall be considered as meeting the requirement.

☐ Public Record Waiver: I request a copy of any public record that the Clinic may obtain about me to be sent to:

I, _____, grant permission to the Kids'
Printed Name of Individual
Community Dental Clinic and its funder (National Children's Oral Health Foundation: *America's ToothFairy®*) to use my image, voice and/or words in informational materials such as reports, brochures, videos, etc. and for media interviews. I waive all claims for compensation and release the Kids' Community Dental Clinic and the National Children's Oral Health Foundation: *America's ToothFairy)* from any liability related to such use. Initial here:_____

Thank you for your willingness to support the children in our community!
*Please attach photocopies of these items for our records.

I certify that all of the information completed above is correct:_____
Applicant's Signature