

GIVE KIDS A SMILE VOLUNTEER SIGN-UP FORM

Clinic October 29 & 30, 2010

PLEASE COMPLETE ALL FIELDS (PRINT OR TYPE):

FORM CANNOT BE PROCESSED IF ANY FIELDS ARE LEFT BLANK

If you have participated in February 2009 GKAS, you may call & update information rather than fill out a new form. Call 636-39Smile (636-397-6453)!

NAME: _____
LAST FIRST MIDDLE DEGREE

HOME ADDRESS: _____
Apt. /Street CITY STATE ZIP

Home Telephone # () _____ (CELL PHONE # () _____)

PERSONAL E-MAIL ADDRESS: _____

DENTAL OFFICE OR ORGANIZATION: _____

ADDRESS: _____
Apt. /Street CITY STATE ZIP

OFFICE PHONE # () _____ OFFICE FAX # () _____

OFFICE E-MAIL ADDRESS: _____

I AM A RETURNING VOLUNTEER: _____ YES _____ NO

*****DOCTORS, PLEASE BRING YOUR OWN ASSISTANTS (EACH BEING SIGNED UP INDIVIDUALLY)*****

Clinic Set Up: _____ Thursday: Oct 28, 2010 5:00 P.M.– 8:00 P.M.

Clinic Break Down: _____ Saturday: Oct 30, 2010 2:30 P.M. - 5:00 P.M.

Clinic Participation: _____ Friday: Oct 29, 2010 7:30 A.M. – 5:00 P.M.

_____ Saturday: Oct 30, 2010 7:30 A.M. – 3:00 P.M.

SELECT A POSITION: (3 hours of continuing education credits will be issued per **each full day** of participation)

1.....Dentist, Dental Resident, Dental Student, Pre-Dental Student, Speciality: _____ School: _____ Year in School: _____ Professional License # _____ State Licensed: _____	5..... Physician, Medical Student Speciality: _____ School: _____ Year in School: _____ Professional License# _____ State Licensed: _____
2..... Dental Assistant, Dental Assistant Student Speciality: _____ School: _____ Year in School: _____	6..... Audiologist, Audiology Student School: _____ Year in School: _____ Professional License# _____ State Licensed: _____
3..... Dental Hygienist, Dental Hygiene Student School: _____ Year in School: _____ Professional License # _____ State Licensed: _____	7..... Dietary and Nutrition: Speciality: _____ School: _____ Year in School: _____ Professional License# _____ State Licensed" _____
4..... Nurse, Nursing Student Speciality: _____ School: _____ Year in School: _____	8..... AMBASSADOR: Speciality: _____ School: _____ Year in School: _____

COMMENTS: (Anything information that would help assign you in our clinic)

PLEASE FAX OR MAIL YOUR FORM TO:

GKAS
340 A MID RIVERS MALL DRIVE
ST. PETERS, MO 63376
636-39SMILE (636-397-6453)
FAX: 1-636-278-2676