CHRISTIAN MOBILE DENTAL CLINIC

VOLUNTEER APPLICATION & INTEREST FORM

Please fill in as applicable

Dentist: _____ Dental Hygienist: _____ Dental Assistant: _____

Dentist's Specialty, if any:____

Name:____

Work Phone: ______________________ Home Phone:___________________________

E-mail:____ Fax:______________________

Contact Address:____

City: _____________________________ State: _________ Zip Code:_______________

Professional License #:__________________________ Active_____ Retired ______
(Please submit a copy of your license with this application.)

Would you be willing to donate a 4-hour OR 8-hour session per month or per quarter at the clinic? 4 hours Yes____ No____ 8 hours Yes____ No____ Month_____ Quarter_____

Other (Please specify):____

Days of the week you are available?

Tue: *am*__*pm*__ Wed: *am*___*pm*___ Thu: *am*___*pm*__ Fri: *am*___*pm*___ Sat: *am*___*pm*___

For dentists: Would you bring staff to work with you? **(Please specify)** ________________________
Would you be willing to take referrals into your practice at no charge? Yes____ No____

If yes, how many referrals would you take per: Month: _________ Year:________

Languages spoken other than English :____

Are you a member of a church? Yes____ No____ If yes, please list the name and address

of the church. ____

Signature:____ Date:______________________

Questions/Comments: ____

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