GIVE KIDS A SMILE
VOLUNTEER SIGN-UP FORM

Clinic February 10-11, 2012

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: Feb. 9, 2012	5:00 P.M.– 8:00 P.M.
Clinic Break Down:	_______Saturday: Feb. 11, 2012	2:30 P.M. - 5:00 P.M.
Clinic Participation:	_______ Friday: Feb. 10, 2012	7:30 A.M. – 5:00 P.M.
	_______ Saturday: Feb. 11, 2012	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, (if student school name, year) **Specialty:**__________________ **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 (if student school name, year) **Specialty:**________________ **School:**__________________ **Year in School:**______________	**6……. Audiologist, Audiology Student** **School:**_______________ **Year in School:**___________ **Professional License#**_________ **State Licensed:**___________
3……. Dental Hygienist, Dental Hygiene Student (if student school name, year) **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