

# GIVE KIDS A SMILE VOLUNTEER SIGN-UP FORM

Clinic October 26 & 27, 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: Oct. 25, 2012 5:00 P.M.– 8:00 P.M.

Clinic Break Down: \_\_\_\_\_ Saturday: Oct. 27, 2012 2:30 P.M. - 5:00 P.M.

Clinic Participation: \_\_\_\_\_ Friday: Oct. 26, 2012 7:30 A.M. – 5:00 P.M.

\_\_\_\_\_ Saturday: Oct. 27, 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)

<b>1.....Dentist, Dental Resident, Dental Student, Pre-Dental Student,</b> Speciality: _____ School: _____ Year in School: _____ Professional License # _____ State Licensed: _____	<b>5..... Physician, Medical Student</b> Speciality: _____ School: _____ Year in School: _____ Professional License# _____ State Licensed: _____
<b>2..... Dental Assistant, Dental Assistant Student</b> Speciality: _____ School: _____ Year in School: _____	<b>6..... Audiologist, Audiology Student</b> School: _____ Year in School: _____ Professional License# _____ State Licensed: _____
<b>3..... Dental Hygienist, Dental Hygiene Student</b> School: _____ Year in School: _____ Professional License # _____ State Licensed: _____	<b>7..... Dietary and Nutrition:</b> Speciality: _____ School: _____ Year in School: _____ Professional License# _____ State Licensed" _____
<b>4..... Nurse, Nursing Student</b> Speciality: _____ School: _____ Year in School: _____	<b>8..... AMBASSADOR:</b> Speciality: _____ School: _____ Year in School: _____
<b>COMMENTS: (Anything information that would help assign you in our clinic)</b> _____ _____	

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**