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)****

<table>
<thead>
<tr>
<th>SELECT A POSITION: (3 hours of continuing education credits will be issued per each full day of participation)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1…….Dentist, Dental Resident, Dental Student, Pre-Dental Student, Specialty: ____________________________ School: ____________________________ Year in School: ____________________________ Professional License # ____________________________ State Licensed: ____________________________</td>
</tr>
<tr>
<td>2…….Dental Assistant, Dental Assistant Student Specialty: ____________________________ School: ____________________________ Year in School: ____________________________</td>
</tr>
<tr>
<td>3…….Dental Hygienist, Dental Hygiene Student Specialty: ____________________________ School: ____________________________ Year in School: ____________________________ Professional License # ____________________________ State Licensed: ____________________________</td>
</tr>
<tr>
<td>4…….Nurse, Nursing Student Specialty: ____________________________ School: ____________________________ Year in School: ____________________________</td>
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<tr>
<td>5…….Physician, Medical Student Specialty: ____________________________ School: ____________________________ Year in School: ____________________________ Professional License # ____________________________ State Licensed: ____________________________</td>
</tr>
<tr>
<td>6…….Audiologist, Audiology Student Specialty: ____________________________ School: ____________________________ Year in School: ____________________________ Professional License # ____________________________ State Licensed: ____________________________</td>
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<tr>
<td>7…….Dietary and Nutrition: Specialty: ____________________________ School: ____________________________ Year in School: ____________________________ Professional License # ____________________________ State Licensed: ____________________________</td>
</tr>
<tr>
<td>8…….AMBASSADOR: Specialty: ____________________________ School: ____________________________ Year in School: ____________________________</td>
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</tbody>
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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