Please Print

PERSONAL INFORMATION **Date of Application:**______________________________

Name:____
Primary Office Address: ____
____ Phone: ____________________
Secondary Office Address: ____
____ Phone: ____________________
Residence Address: ____
____ Phone: ____________________
Date of Birth: _____________ Birth Place: ___________________________ Spouse's Name: __________________

EDUCATION
Dental School: ____ Year Graduated: __________________

Post Graduate Education: ____________________________ Degree _________________ Year ________________
Hospital Training: ____
Type & Date Completed: ____
Fellowship or Teaching Appointments:____

LICENSES & CERTIFICATIONS
State Licenses Held: ____ License Number: _________________
____ License Number: _________________
Specialty: ____________________________________ Board Certified ________ Board Eligible ________
Practice Limited To: ____

Have you ever been disciplined by any state licensing agency or department? If yes, please give details and findings:
____
____
Have you ever been convicted of a felony or first degree misdemeanor? (This does not include traffic violations).
If yes, please give details and findings: ____
____
Have you ever had a judgment of malpractice entered against you? If yes, please include details and findings:
____

DENTAL ASSOCIATION MEMBERSHIPS
Are you a member of the Florida Dental Association? Yes No If yes, FDA # _________________
Have you ever applied for membership in the Florida Dental Association? Yes No

I hereby certify that the information contained herein is true and correct and if subsequently proved incorrect shall be grounds for disapproval and/or removal.

Date: _______________________________ Signature: ____

Please have 2 members of the South Palm Beach County Dental Assn. endorse your application by signing below:

Print Name: __________________________ Signature: ____

Print Name: __________________________ Signature: ____

If you would like referrals, please answer the following questions:

1.	**Accept Emergencies**	**Yes ___**	**No ___**
2.	**Evening Hours**	**Yes ___**	**No ___**
3.	**Saturday Hours**	**Yes ___**	**No ___**
4.	**House/Nursing Home Calls**	**Yes ___**	**No ___**
5.	**Nitrous Oxide Analgesia**	**Yes ___**	**No ___**
6.	**General Anesthesia/IV Sedation**	**Yes ___**	**No ___**
7.	**Do You Make Dentures?**	**Yes ___**	**No ___**
8.	**Languages Other Than English** **Please specify __________________**	**Yes ___**	**No __**
9.	**Accept Medicaid**	**Yes ___**	**No ___**
10.	**Accept Insurance Assignment**	**Yes ___**	**No ___**
11.	**Accept Major Credit Cards**	**Yes ___**	**No ___**

IF YOU WISH TO WORK ON ANY OF THE FOLLOWING COMMITTEES, PLEASE INDICATE YOUR CHOICE(S) BELOW:

COUNCIL ON ASSOCIATION AFFAIRS

______ Audit & Budget
______ Constitution & By-Laws
______ Membership
______ Relief & Chaplains
______ Nominations
______ Censors & Ethics

COUNCIL ON DENTAL CARE

______ Peer Review
______ Dental Care

COUNCIL ON DENTAL EDUCATION

______ Programs & Cont. Education
______ Dental Education
______ Receptions & Arrangements

COUNCIL ON GOVERNMENTAL AFFAIRS

______ Legislation

COUNCIL ON COMMUNICATION

______ Consumer Education & Relations
______ Children's Dental Health Month

We have a community service project to treat indigent individuals. It is called **PROJECT: DENTISTS CARE.** We expect all members to volunteer their services.
Please indicate your choice: Day _____ Evening _____ Saturday _____

PLEASE COMPLETE THIS FORM, ENCLOSE $160.00 APPLICATION FEE & MAIL TO:
Dr. Ethan A. Pansick
14000 Military Trail, Suite 110
Delray Beach, FL 33484

FOR S.P.B.C.D.A. USE ONLY

Date Application Received: ________________________
Status with FDA ________________________
Status with DPR ________________________
Date of First Reading ________________________
Published in Newsletter ________________________

Year Graduated ________________
Dues Review ________________
Membership Type________________
Final Action by BOT________________