

**THANK YOU FOR VOLUNTEERING FOR DONATED DENTAL SERVICES!!**  
**Please fill out the information below and fax it back to**  
**Tahira Bazile at 916.498.6145**

\*First Name: \_\_\_\_\_ \*Last Name: \_\_\_\_\_

\*Address: \_\_\_\_\_

\*City: \_\_\_\_\_ \*State: \_\_\_\_\_ \*Zip: \_\_\_\_\_ \*County: \_\_\_\_\_

Office Phone: \_\_\_\_\_ Fax Number: \_\_\_\_\_

E-Mail: \_\_\_\_\_

State or Local Dental Association/Society/Component: \_\_\_\_\_

1. Are you a: General Dentist \_\_\_\_\_ Specialist \_\_\_\_\_  
Specialty: \_\_\_\_\_

2. Is your office wheelchair accessible? Yes \_\_\_\_\_ No \_\_\_\_\_

3. Do you have hospital(s) privileges? Yes \_\_\_\_\_ No \_\_\_\_\_  
Which hospital(s)? \_\_\_\_\_