For SAS Use Only	
Mtg w/ dentist/staff ☐	_____
Credentials verified ☐	_____
ROI form ☐	_____
SAM ☐	_____

Dentist Volunteer Application

(ALL VOLUNTEER DENTISTS MUST CURRENTLY BE LICENSED IN THE STATE OF TEXAS)

Name: _____ Dental license #:_____

Office Name: _____ Address: _____

City: _____ State: _____ Zip: _____

Office phone: _____ Fax: _____

Dentist email: _____ Office staff email: _____

Web site: _____ Are your patient forms available on-line? ☐ Yes ☐ No

Does your office prefer that new patients complete on-line registration and forms before the first visit? ☐ Yes ☐ No

☐ General dentist ☐ Specialist _____

Office contact person: _____

Office hours and days (include lunch hours): _____

Age/grade of children you are willing to treat? _____ How many children are you willing to treat yearly? _____
(Target age group is pre-K through 6th grade)

Do you or any staff members speak a foreign language? No ☐ French ☐ Spanish ☐ Sign language ☐
Vietnamese ☐ Other: _____

Is your office equipped with nitrous oxide? ☐ Yes ☐ No

What procedures are you willing to provide?

☐ Preventative care	☐ SSC	☐ Space maintainers	☐ Dental screenings
☐ Restorations	☐ Pulpotomies	☐ In-office sedation	☐ Dental screenings **ONLY**
☐ Sealants	☐ Extractions		

☐ O.R. (pediatric dentists) List facilities you are credentialed at: _____

List any preferences you have on how or when appointments for Save a Smile patients are scheduled: _____

_____

_____

_____

How did you hear about Save a Smile? _____

May we list you as a volunteer of the Save a Smile program in printed material/literature/web site? ☐ Yes ☐ No

Email the completed volunteer application to saveasmile@cookchildrens.org or fax to 682-885-7286

For more information visit centerforchildrenshealth.org, email saveasmile@cookchildrens.org or call 682-885-6731

COMPLETE BACK SIDE OF FORM

Revised front side, reviewed back side 6/27/2019
Updated SAS logo 6/12/2020

Cook Children's

For Staff Use Only:
Adult - ☒
Junior - ☐
(Please check one)

Authorization for Release of Information to Cook Children's Health Care System

Pursuant to the requirements of the Fair Credit Report Act, notice is given that a **consumer report/ criminal background check** will be made in connection with your initial application for volunteer placement and that subsequent consumer reports/criminal background checks may be generated throughout your volunteer experience at Cook Children's.

If you are denied a volunteer position, either wholly or partly, because of information contained in a consumer report/ criminal background check, a disclosure will be made to you of the name and address of the consumer reporting agency making such report. You will also receive a copy of the report and a statement of your consumer rights.

I have read the above notice and understand what it means. I am providing the requested information voluntarily, and hereby authorize the procurement of a consumer report/criminal background check for volunteer placement.

I hereby authorize Cook Children's Health Care System, or its duly accredited representatives, to request, receive and investigate any and all background information about or concerning me. I hereby authorize employers, educational institutions, and my personal and volunteer services references to furnish Cook Children's Health Care System with any information they may have concerning me with they may have on record or otherwise.

I understand that Cook Children's Health Care System will decline to accept me as a volunteer if there are ***any*** arrests, convictions, nolo contendere pleas, deferred adjudications, or any other criminal entries on my record. I understand that this decision is in no way intended to reflect negatively toward me; nor will factors such as race, sex, age, national origin, disability status or marital status be considered in any decision. Any inaccurate information or omissions may result in being denied the opportunity to serve as a volunteer at Cook Children's Health Care System.

I hereby fully release and discharge Cook Children's Health Care System, its respective affiliates, subsidiaries, directors, officers, employees, agents and attorneys thereof, and each of them, and any individual, organization, entity, agency or other source providing information to Cook Children's Health Care System from all claims and damages arising out of or relating to any investigation of my background for volunteer placement.

If placed as a volunteer, this authorization shall remain on file and shall serve as ongoing authorization for Cook Children's Health Care System to procure consumer reports/criminal background checks at any time during my volunteer placement period.

Name of Applicant_____
(PLEASE PRINT) (LAST) (FIRST) (MIDDLE)

Social Security No._____ **Date of Birth**_____ **Gender** ☐ Male ☐ Female
FOR CONSUMER REPORT PURPOSES ONLY* MM-DD-YYYY (PLEASE CIRCLE ONE)

Ethnicity: ☐ African American * ☐ American Indian * ☐ Anglo / Caucasian * ☐ Asian * ☐ Hispanic * ☐ Other (PLEASE CIRCLE ONE)

_____
(SIGNATURE OF APPLICANT) **(DATE SIGNED)**

_____
(SIGNATURE OF PARENT IF UNDER 18) **(DATE SIGNED)**

Please list below:

Current Residence Address (Not PO Box)	**Other Cities, States, and Counties where you have lived**
Street Address:	
City:	
State: **Zip Code:**	

Please complete all HIGHLIGHTED portions

For Staff Use Only:

Staff Member Initials: _____ Date Input: _____ Date Received:_____ Result: Pass / Fail