MINNESOTA DENTAL FOUNDATION
A practice of giving.

Retired Dentist Program Application

Name: _____
Last First Middle Initial

Mailing Address: _____

City, State, Zip: _____

Phone (home): _____ Phone (cell): _____

E-mail: _____

Are you receiving any income from a dental activity such as patient care, teaching, consulting, or administration where a license is required? Yes _____ No _____

Do you have an active license to practice dentistry in Minnesota?
Yes _____ No _____ License Number: _____ Expiration Date: _____

Do you currently have professional liability insurance? Yes _____ No _____

Company: _____

Policy Number: _____ Expiration Date: _____
Please attach a copy of the declaration page.

In the past 5 years has any disciplinary action been initiated or are you aware of any pending actions against you by any state licensing board?
Yes _____ No _____ If yes, please explain on an additional page.

In the past 5 years has your license to practice in any state been suspended or revoked?
Yes _____ No _____ If yes, please explain on an additional page.

Name of office or clinic where you intend to provide patient care:

Name: _____

Address: _____

I certify that all information contained on this application and any attached pages is true and accurate to the best of my knowledge.

Signature: _____ Date: _____

Return to: Minnesota Dental Foundation, 1335 Industrial Blvd, Suite 200, Minneapolis, MN 55413 or fax to 612-767-8500.