Crown Dental Plan

Crown Dental Plan, Inc.
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DENTIST: APPLICATION FOR MEMBERSHIP

NAME: ____

OFFICE ADDRESS/ADDRESSES: ____

____

TELEPHONE #: ________________________ FAX #: __________________________

E-MAIL ADDRESS: ____

OFFICE HOURS: ____

AREAS OF SPECIALIZATION: ____

STATE(S) LICENSE(S) #: _____________________________________

DENTAL SCHOOL: ____

YEAR OF GRADUATION/DEGREES ____________________________

ADA MEMBER ( ) YES ( ) NO

ADDITIONAL PROFESSIONAL ASSOCIATIONS: _______________________________

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MALPRACTICE LIABILITY INSURANCE CO: __________________________________

LIMIT OF LIABILITY: ____

ARE YOU CURRENTLY INVOLVED IN MALPRACTICE LITIGATION? ( ) YES ( ) NO
If yes, please explain – attach photocopy of explanation

SIGNATURE: ______________________________________ DATE: _________________

Please attach the following photocopies:

STATE LICENSE(S) DEA LICENSE FACE PAGE OF MALPRACTICE POLICY