

Appendix A:

THE ANGEL PROGRAM APPLICATION AND AGREEMENT FORM

I agree to participate in THE ANGEL PROGRAM within the Sothern Nevada Dental Society and to abide by the terms and conditions of the agreement established therefore. I understand that I may be called upon by (President Elect) to provide professional services in the office of a fellow participant of the program who, due to illness or accident, is unable to practice dentistry. In the event of death, the same assistance will be provided in accordance with the provision of the program until disposition of the practice has been completed not to exceed 120 days whichever comes first. In consideration for my participation, I will receive the same assistance from the program when and if needed.

Signed: _____ DMD/DDS.

Spouse: _____

Application:

Member name: _____

Office Address: _____

Type of Practice: _____

What is referred out? _____

Cell phone: _____

Work Phone: _____

Home Phone: _____

Office manager: _____ Cell: _____

Practice management system: _____

Office hours: (list all days and hours open)