

GRANT APPLICATION FOR DENTISTS AFFECTED BY DISASTER

(Please Print Clearly All Information on This Form)

Name _____

Office Address _____ City, State, Zip _____

Home Address _____ City, State, Zip _____

Telephone (Home) _____ (Office) _____ E-Mail _____

Plases provide your temporary contact information:

Address _____ City, State, Zip _____

Telephone/Cell _____ E-Mail _____

Briefly describe the nature and date of the disaster and provide details on the property damage sustained (attach additional sheet if necessary).

Briefly describe how you plan to use emergency funds (attach additional sheet if necessary).

Do you have insurance coverage for your practice facility? _____

What is the net loss after insurance coverage? \$ _____

Do you have insurance coverage on your home? _____

What is the net loss after insurance coverage? \$ _____

Name of Insurance Company _____

What is your estimate of your total loss in this disaster? (excluding lost income) \$ _____

Nature of financial resources (please indicate the extent of your financial insurance as expected by this disaster).

What is your approximate net worth? \$ _____

Please indicate whether or not you are able to use your available resources to help with this disaster?

Certification by Applicant

I certify that I have suffered a disaster to my dental practice and/or residence as stated in this application.

I certify that the information contained in this application is true and complete. I understand that a fraudulent representation or omission of any information requested is grounds for immediate refusal to grant assistance under this program.

I understand that the granting of such assistance is neither a right nor entitlement and that the Board of Directors of the ADA Foundation shall have sole discretion in determining whether I qualify for assistance.

Signed _____ Date _____

Affirmation of Dental Society

This is to verify that the applicant named herein is a dentist and has suffered a disaster and that the information contained herein is true and complete to the best knowledge of the investigator. The investigator recommends emergency assistance for this applicant.

Signed _____ Date _____
Executive Director/Designated Officer, Component/Constituent Society

Please forward your completed and signed application to your state dental society by fax or regular mail. For Florida only: 1111 E. Tennessee St., Tallahassee, FL 32308; Fax – (850) 681-0116.

**THE ADA FOUNDATION
211 EAST CHICAGO AVENUE
CHICAGO, ILLINOIS 60611
(312) 440-2763**

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