



DONATED ORTHODONTIC SERVICES (DOS) PROVIDER APPLICATION FORM

ORTHODONTIST NAME: _____

OFFICE ADDRESS: _____

CONTACT PERSON: _____ PHONE: _____

I will donate my and my office's time and efforts to treat _____ DOS patients every ____ year(s).

We suggest that each participating orthodontist accept at least one patient every year, with a minimum participation of accepting one patient every 2 years.

If you would like to donate your services at multiple office locations please fill out a form for each location.

By signing this form I agree that:

- 1) I am a member of the NJAO, MASO, and the AAO in good standing.
- 2) I will treat any patient treated under the DOS program with the same level of professionalism and care as any other patients treated by me.
- 3) I agree to assume all legal responsibility regarding any orthodontic care rendered to patients treated by me under the DOS program.
- 4) I agree to not hold the NJAO or the AAO liable for any orthodontic care rendered under the DOS program.

Please Print Name: _____

Signature: _____ Date _____

Please return to:
 New Jersey Association of Orthodontists
 4781 Steeplechase Dr.
 Macungie, PA 18062
 Fax: 610-395-5669