THE DENTAL PPA ~ DENTAL PROVIDER APPLICATION

Confidential Document Please Print or Type

1. Dentist's name as it appears on dental license: _____
2. Dentist's name as it should appear in the provider directory:

   Name: _____ o ***General Practice*** o ***Specialty***: _____

   Address: _____

   Bus Phone #: _____ **Fax #:** _____ **Email Address:** _____

3. Have you been charged or threatened with a charge for unprofessional conduct by any person at any time during the preceding five-years? ( ) Yes ( ) No

4. Have you ever been convicted of a felony? ( ) Yes ( ) No

5. Has any committee of the State or local Dental Association ever censured you with regard to ethics or fees? ( ) Yes ( ) No

6. Have you been a party in any lawsuit, action or proceeding involving professional malpractice within the preceding five-years? ( ) Yes ( ) No

7. Since you initially obtained your license to practice dentistry in the State of California, have you ever been required to appear before the California Board of Dental Examiners for disciplinary action? ( ) Yes ( ) No

8. Has any disciplinary action ever been taken against you, or is any such action presently pending or threatened, which resulted in or could result in any suspension or revocation of the license listed above or which resulted in or could result in any suspension or revocation of any hospital or staff privileges which you have been granted in any state? ( ) Yes ( ) No

Provider Agreement Compliance

I, _____, have read The Dental PPA Provider Agreement and agree to abide by all terms and conditions set forth in said Agreement until such time as I, _____, submit my written notice of termination of membership in The Dental PPA. Applicant's Initials: _____

Application Certification

I hereby certify that the above information is accurate and true and understand all information included in this application is strictly confidential.

Any information entered into this application, which is subsequently found to be false could result in my immediate termination from membership in The Dental PPA. I am aware that the application fee is non-refundable.

INFORMATION RELEASE FORM

I hereby authorize the release to The Dental PPA, or Legacy Enterprises, their consultants, true copies of historical, utilization, and credentialing data, information that may be obtained from individuals, universities, and other entities as provided upon my application.

I hereby attest to the correctness and completeness of all information furnished in my application and I release from liability all those who in good faith and without malice, review, act on, or provide information regarding my competence, professional ethics, character, health status, and other qualifications for participation in The Dental PPA.

_____ _____

Signature of Applicant Date

_____ _____

Print Name of Applicant Tax ID or Social Security Number
As you submit to claim administrators