

APPLICATION FOR CERTIFICATE OF RECOGNITION FOR VOLUNTEER SERVICE IN A FOREIGN COUNTRY

*Complete Parts I, II, and III, and forward to the Nominee's Constituent or Component Dental Society for completion of Part IV and submission to the ADA for approval. (This form **is not to be used by dental students** – dental students **must** use the form **S**, designated for dental students.)*

(Please Type or Print)

PART I **Nominee Information**

Full Name of Nominee: _____

Degree: _____

ADA Number: _____ - _____ - _____

Address: _____

Character of Practice: _____
(Specify General Practice, Teacher, Other)

If Teacher, specify Dental School:

PART II **Testimonial Letter**

Attach a testimonial letter or document from the on-site administrator or appropriate official, verifying that the above stated volunteer service was performed as described.

Name of Administrator Supplying the Testimonial Letter: _____

Telephone: _____ Organization: _____

Address: _____

PART III Description of Service – List most recent first – Make additional copies of this page if more space is needed.

Breakdown of Activities: Check all types of assistance provided and enter the number of hours worked per day.

please mark all that apply

Country Assigned:	<input type="checkbox"/> Patient Teaching/Training	hrs./day
*Sponsor/Program:	<input type="checkbox"/> Community Teaching/Training	hrs./day
Duration:	<input type="checkbox"/> Oral Surgery (extractions)	hrs./day
Specific Dates:	<input type="checkbox"/> Restorative	hrs./day
	<input type="checkbox"/> Preventive	hrs./day
	<input type="checkbox"/> Diagnostics	hrs./day
	<input type="checkbox"/> Other: _____	hrs./day

Breakdown of Activities: Check all types of assistance provided and enter the number of hours worked per day.

please mark all that apply

Country Assigned:	<input type="checkbox"/> Patient Teaching/Training	hrs./day
*Sponsor/Program:	<input type="checkbox"/> Community Teaching/Training	hrs./day
Duration:	<input type="checkbox"/> Oral Surgery (extractions)	hrs./day
Specific Dates:	<input type="checkbox"/> Restorative	hrs./day
	<input type="checkbox"/> Preventive	hrs./day
	<input type="checkbox"/> Diagnostics	hrs./day
	<input type="checkbox"/> Other: _____	hrs./day

*Religious, Voluntary, or other Nonprofit Organization

Part IV Submission

(To be completed by officer of Nominee's **Constituent or Component Dental Society**)

Nomination **must** be made by the Nominee's **Constituent or Component Dental Society**.

(Please Type or Print)

Name of Nominating Society: _____

Name of Dental Society Officer: _____ Title: _____

Signature

Date

If Nominee is approved, Certificate should be sent to: Society Nominee

Please forward this completed Nomination Form by deadline March 31 to:

**Director
Center for International Development and Affairs
American Dental Association
211 E. Chicago Ave.
Chicago, IL 60611**

Telephone: 312/440-2726
Fax: 312/587-4735