

**WEST COAST DISTRICT DENTAL ASSOCIATION FUND  
Hurricane Immediate Relief Application**

**Applicant Information:**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ County: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

FL Dental License #: \_\_\_\_\_ Dental Lab Registration #: \_\_\_\_\_

**Nature of Disaster:** - Provide a description of the disaster. You may attach supporting documents and pictures. Please be date specific. \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
(Use back of this form if necessary)

**Amount of Damage:**

Structure:	\$ _____	Total Damage:	\$ _____
Equipment	\$ _____	Insurance Coverage	\$ _____
Supplies	\$ _____	Net Loss after Insurance	\$ _____

How will the \$500 be used to assist you during this time? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
**I hereby certify the information contained in this document is true and complete. I hereby authorize any corporation, firm, agency or institution to furnish to the West Coast District Dental Association with any and all information in its possession relative to my assets, deposits, dealings or business of any kind whatsoever.**

\_\_\_\_\_  
Signature of Applicant  
**(Must be signed with notary present)**

\_\_\_\_\_  
Date

State of FL \_\_\_\_\_ County of \_\_\_\_\_

On the \_\_\_\_\_ day of \_\_\_\_\_ in the year two thousand and \_\_\_\_\_ before me personally came \_\_\_\_\_ to me known, and known to me to be the individual described in and who executed the foregoing instrument, and he/she acknowledged to me that he/she executed the same.

\_\_\_\_\_  
Notary Public  
My commission expires:

**Return application to:**  
West Coast District Dental Assn.  
9720 North Armenia, #F  
Tampa, Florida 33612

Date received at West Coast office:  
\_\_\_\_\_