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 Date
(Must be signed with notary present)

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.
1114 Kyle Wood Lane
Brandon, Florida 33511

Date received at West Coast office:
_____