

**All information on this profile is required for membership. Failure to provide required information will impact your membership status with Washington Dental Service.**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Gender:    \_\_\_\_\_  
 Social Security #: \_\_\_\_\_ WA state license #:    \_\_\_\_\_ DEA #: \_\_\_\_\_    \_\_\_\_\_  
 Other state license #: \_\_\_\_\_ State: \_\_\_\_\_  
 Dental school: \_\_\_\_\_ Graduation Year: \_\_\_\_\_  
 Graduate Dental Program: \_\_\_\_\_ Graduation Year: \_\_\_\_\_

ADA recognized specialty: **Please attach a copy of your specialty certificate.**

- General Practice     Endodontics     Oral Surgery     Pediatric Dentistry     Periodontics  
 Prosthodontics     Orthodontics

• **Please attach a work history or Curriculum Vitae** covering the last five years. Include an explanation of any gaps in work history that are greater than six months.

• **Please attach a copy of your current malpractice certificate.**

• Hospital privileges     Yes\*\*     No    \*\* Please attach a verification letter from the hospital

• My office meets all Infection Control/OSHA and WISHA requirements:     Yes     No

• For each affirmatively checked response, please include a brief description on a separate sheet of paper and submit with this form.

Are there any reasons for any inability to perform the essential function of the position, with or without accommodations?     Yes     No

Has your license to practice dentistry in any jurisdiction been voluntarily surrendered, limited, suspended, or revoked?     Yes     No

Have you ever been subject to review, challenges, and/or disciplinary action, formal or informal, by an ethics committee, licensing board, dental disciplinary board, professional association or education/training institution?     Yes     No

Have you been found by a state professional disciplinary board to have committed unprofessional conduct as defined in applicable state provisions?     Yes     No

Have you had any malpractice claims, suits, or settlements within the last five years?     Yes     No

Do you presently, or have you ever, used illegal drugs?     Yes     No

Do you have any history of felony convictions?     Yes     No

I hereby certify that the information requested by Washington Dental Service and provided herein is truthful, correct and complete in all respects. I further understand that the submission of false or misleading information, or the withholding of relevant information, is grounds for termination as a participating dentist with the dental plan. I hereby agree to notify WDS of any changes in the above information.

**Dentist Rights**

The dentist has the right to review all credentialing information, and obtain the current status during the application process.

The dentist has the right to correct any erroneous or variant information obtained during the credentialing process.

The dentist may request the initial application be revisited if corrections are made within 180 days of the credentialing decision, or may re-apply if the 180 day time requirement has lapsed.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**AUTHORIZATION FOR RELEASE OF INFORMATION**

I authorize Washington Dental Service and their personnel to contact professional liability carriers, schools and universities, and other persons or entities, to obtain information concerning my professional qualifications, including education, competence, ethics and other information pertinent to providing dental services. I hereby release all parties and persons connected with any requests for information from all claims, liabilities, and damages for whatever reason arising out of furnishing such information.

**This authorization is required in order to perform the verifications required for credentialing. You must be credentialed in order to become a Delta Dental member dentist. To avoid a delay in processing your application, please be sure to sign and return the authorization along with your other application forms.**

Name: \_\_\_\_\_  
*(Please print)*

License #: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**RELEASE TO PRODUCE ADDITIONAL CERTIFICATE OF INSURANCE COVERAGE**

I hereby authorize release of the following professional liability insurance information to Washington Dental Service.

(Insurance Co Name) \_\_\_\_\_  
Address \_\_\_\_\_ Phone # \_\_\_\_\_  
Address 2 \_\_\_\_\_ Fax # \_\_\_\_\_  
City, St Zip \_\_\_\_\_ Policy Number \_\_\_\_\_

From which I purchase my **professional liability**

Please produce an additional certificate of insurance coverage for:  
Washington Dental Service  
P.O. Box 75983  
Seattle, WA 98175.

The certificate should be mailed to Washington Dental Service at each renewal until otherwise notified or upon termination of coverage.

\_\_\_\_\_  
(Doctors Signature) (Date)  
  
\_\_\_\_\_  
(Print Name) (License Number)

Insurance Dentist will maintain in full force and effect

- (i) professional liability policy or policies of insurance with an insurance carrier approved by WDS, naming as insured Dentist and each dentist associate with Dentist, and his or her employees agents, with coverage in an amount not less than \$1,000,000 per claim and \$3,000,000 in the aggregate; and
- (ii) premises liability insurance covering his or her offices premises, in amounts of not less than \$500,000 coverage for injury or death of any person and not less than \$1,000,000 coverage for injury or death to more than one person in any one year.

**WORK HISTORY**

List all work history for the past five years chronologically, starting with the most recent:

Name of Practice/Employer: \_\_\_\_\_

From (mm/yyyy): \_\_\_\_\_ To (mm/yyyy): \_\_\_\_\_

Reason for leaving: \_\_\_\_\_

\_\_\_\_\_

Name of Practice/Employer: \_\_\_\_\_

From (mm/yyyy): \_\_\_\_\_ To (mm/yyyy): \_\_\_\_\_

Reason for leaving: \_\_\_\_\_

\_\_\_\_\_

Name of Practice/Employer: \_\_\_\_\_

From (mm/yyyy): \_\_\_\_\_ To (mm/yyyy): \_\_\_\_\_

Reason for leaving: \_\_\_\_\_

\_\_\_\_\_

Name of Practice/Employer: \_\_\_\_\_

From (mm/yyyy): \_\_\_\_\_ To (mm/yyyy): \_\_\_\_\_

Reason for leaving: \_\_\_\_\_

\_\_\_\_\_

\* Please add any additional work history on a separate sheet of paper.

**Please account for all gaps of six months or more:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_