Sharing Smiles Orthodontic Scholarship Application

(updated 10.2019)

Student's Name:_____D.O.B:_____ Gender_____

Name of Parent or Legal Guardian:_____ Relationship to Applicant:_____

Home Address:_____ City:_____ Zip:_____

Home Phone:_____ Cell Phone:_____ Email Address:_____

Name of School:_____ How did you hear about the Scholarship?_____

Name of Dentist:_____ Date of Last Visit:_____

Have you applied for an orthodontic scholarship before? _____

Total Annual Household Income: $_____ How many family member are in the household? _____

Submitted by (circle one): Self Parent Educator Dentist Other _____

The applicant is an excellent candidate for an orthodontic scholarship because:

_____

_____

To be considered for the SHARING SMILES ORTHODONTIC SCHOLARSHIP, Please include the following:

1. Handwritten answers by the applicant for all the questions on the attached Student Questionnaire
2. A copy of last year's tax return, W-2s, or a copy of the most recent pay stubs for all family wage earners.
3. Two 4 x 6 photos of the applicant
    a. One full face photo showing a full smile and the teeth
    b. One close up photo showing the applicant's teeth.
4. Two letters of reference (typed and limited to one page each) from a teacher, coach, community leader or other non-family mentor that knows the applicant.
5. A copy of applicant's last report card or school transcript.

Sharing Smiles Orthodontic Scholarships are awarded after consultation with a committee of local volunteers. The process is competitive, and not all applicants will be awarded an orthodontic scholarship from Dr. Sheffield. Successful candidates will meet the following criteria: a complete application, a combination of demonstrated orthodontic and financial need, a desire to improve him/herself, in addition to giving back to others. Orthodontic services are 100% donated by Robert Sheffield DDS.

The completed application and all supporting documents should be sent to:

SHARING SMILES Orthodontic Scholarship
3428 Hillcrest Avenue, Suite 100
Antioch, CA 94531

For questions: 925-757-3356 or info@Sheffieldortho.com with Orthodontic Scholarship in the subject line.

Note: Applications, pictures and supporting documents will not be returned, and will become the property of Robert Sheffield DDS, Inc. for the sole purpose of evaluating the student for the Orthodontic Scholarship.

Student Questionnaire … TO BE ANSWERED in STUDENT'S OWN WORDS and HANDWRITING.

1) Tell us about yourself. What do you like to do? What school subjects do you like? What activities are you involved in when you aren't at school? What do you want to do when you grow up? How are you working toward your goals?

2) Tell us about your family. How many people live with you, and who are they?

3) Why do you want braces? How do you feel about your smile? How do you think braces will make a difference in your life now and in the future?

4) We think everyone can help others. If you are awarded this ORTHODONTIC SCHOLARSHIP, how can you help others in the community? Be SPECIFIC. If you are awarded the scholarship, we will ask you to update us on what YOU have done to help others.

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The undersigned hereby authorizes Robert Sheffield, DDS to release photograph(s), and information regarding the patient's treatment, including Protected Health Information ("PHI") pursuant to 45 C.F.R. §164.508(a)(3), for the limited purpose of its newsworthiness to the general public, or for human interest, publicity, marketing and/or advertising, concerning:

Patient's Name: _____

These records may be used for promotional or publicity purposes and may appear in mass media publications, on the Robert Sheffield, DDS Inc. internet sites, within other such publications or on similar internet sites, shown in television presentations, and released to media outlets. The patient and/or his/her legal representative agree that the patient's identification including the patient's and family's name may be used in such release(s). This release may be revoked by the patient and/or his/her legal representative at any time, in writing. Such revocation shall only be effective to prevent any expanded future use of the information from the date of revocation of said consent. Otherwise, this release shall continue without expiration. The patient and/or his/her legal representative acknowledge that participation in or treatment, is not conditioned upon agreeing to sign this release.

The patient and/or his/her legal representative also acknowledge that PHI and other information, photographs, films, and the like used for the purposes sought by this release could be disclosed by others who view it and that the PHI may no longer be protected by 45 C.F.R. §164.508(a)(3). Finally, the patient and/or his/her legal representative acknowledge that they have been provided a copy of the signed release regarding these disclosures.

I/we understand and acknowledge the forgoing. All questions regarding the requested disclosures have been answered and I/we voluntarily agree to the disclosures outlined above without limitation.

PARENT OR LEGAL GUARDIAN (if patient is a minor)

Signature _____ _____
Date

Printed Name _____

Address: _____

Phone: _____

WITNESS

Signature _____ _____
Date

Printed Name _____

Address: _____

Phone: _____