THE UNIVERSITY OF TEXAS HOUSTON HEALTH SCIENCE CENTER
DENTAL BRANCH

Name: ____

Last Name First Name Initial Degree (Maiden)

SSN: ___________________________Date of Birth ______________________ (MMDDYYYY)

Will Faculty Member be treating patients? _______Yes___________No

Title and Department: ________________________________

(i.e., Specialist, Staff, Instructor, Asst. Prof., Assoc. Prof., Professor, Faculty, Resident)

Effective Date of appt: _________________________

License No____________Issue Date: _______________Expiration Date: _______________
(COPY OF CURRENT LICENSE MUST BE ATTACHED)

Private Malpractice Coverage: ____Yes_____No (If yes, attach copy)

UT Malpractice Coverage________Yes_____No

Part Time: _____Full Time: ________If part time: what percent______%

Hours worked per month: ________________

__________________________________ ____________________________ ________________

Dentist's Signature Printed Name Date

INTERNAL USE ONLY

****Insurance Service Office Code (ISO) is required for Malpractice Insurance**

Risk Class: _____________**Insurance Service Code_________________________

NAME OF PERSON SUBMITTING DATA: ____

PHONE NO: _______________FAX NO: _______________DATE:______________________

REQUESTED: **FAXED:**

01/2005