Attachment 1

Angle Northern California

CANDIDATE/GUEST INFORMATION FORM
(TO BE COMPLETED BY PRIMARY SPONSOR)

Doctor's Name _____ Date _____
(First) (Middle) (Last)

Office Address _____
(Street) (City) (State) (Country) (Zip)

Office Phone #: _____ Fax # _____ e-mail _____

Sponsor(s) Primary: _____ Secondary: _____

Organized Dentistry Affiliations:

American Dental Association YES ____ NO _____

American Association of Orthodontists YES ____ NO _____

Constituent Orthodontic Society _____ Component Orthodontic Society _____

Dental School _____ Degree _____ Date Conferred _____

Ortho Education _____ Degree _____ Date Conferred _____

The Guest/Candidate is primarily involved in: Clinical Practice_____ Education/Research _____

Who are other Angle members acquainted with the Guest/Candidate? _____

_____

Has the Guest/Candidate completed the Written Examination of the American Board of Orthodontics? Yes_____ No_____
Has the Guest/candidate completed the Clinical Examination of the ABO? Yes_____ No_____ Year _____
Recertified by the ABO: Yes_____ No _____ Date _____

Please provide the following (OK to use the reverse side of this form)

- Guest/Candidate clinical expertise, teaching background, research or publications:

- Personal information regarding the Guest/Candidate:

Please Return to: Dr. Patricia Choi
Secretary, Angle Northern California
2111 Parkside Dr, Suite A
Fremont, CA 94536
(510) 792-2308 **fax**
pattychoi@gmail.com