WD PLAN
GROUP AND INDIVIDUAL

A SEPARATE FORM MUST BE COMPLETED FOR EACH DENTIST IN YOUR OFFICE

Doctor Name: _____

Facility Name: _____

Social Security Number _____/_____/_____ Date of Birth_____/_____/_____

School Attended_____ Year Graduated _____

Work History (for the past 5 years)

Please list all your current and previous dentistry-related work experience and advanced education (specialty school, residency or fellowship) in the last five (5) years. Include months and years for each entry. If practicing less than 5 years, please go back to the month and year of licensure. For gaps in work history of 30 days or more, explanation is required.

1. Practice Name | Phone
   Address
   City | State | Zip
   Start Date (MONTH/YEAR) | End Date (MONTH/YEAR)

2. Practice Name | Phone
   Address
   City | State | Zip
   Start Date (MONTH/YEAR) | End Date (MONTH/YEAR)

3. Practice Name | Phone
   Address
   City | State | Zip
   Start Date (MONTH/YEAR) | End Date (MONTH/YEAR)

4. Practice Name | Phone
   Address
   City | State | Zip
   Start Date (MONTH/YEAR) | End Date (MONTH/YEAR)

5. Practice Name | Phone
   Address
   City | State | Zip
   Start Date (MONTH/YEAR) | End Date (MONTH/YEAR)