ASSOCIATE INFORMATION & PREFERENCES

IMPORTANT: ***The information supplied below will be treated in a confidential manner***. You do not incur any obligation by completing this questionnaire. ***You will not incur any cost or charge associated with our search for an associate position***. If you have questions related to this questionnaire, or our services, feel free to contact us by phone or e-mail.

PLEASE PRINT CLEARLY (Fax transmission deteriorates legibility.)

Date: _____

Name: _____ Contact Info: Home Phone: _____

Address: _____ Cell Phone: _____

City:_____ _____ St: ___ Zip:_____ Home Fax: _____

Is Your Inquiry Confidential? _____ E-mail: _____

Check: (__) General Dentistry or (__) Specialty: _____ Do you check e-mails frequently? ___

REGARDING THE ASSOCIATE POSITION THAT YOU SEEK:

List towns/cities, or describe areas/locations in which you would consider an associate position:

_____

_____

Describe aspects of a practice that would be important in your selection of an associate position:

_____

_____

_____

_____

Other comments about the position you seek/want: _____

_____

Annual gross production/collection you hope to achieve as an associate: $_____ to $_____

Income range that you expect as an associate: $_____ to $_____

By what date do you wish to have an associate position? _____

Are you limited in locations by a restrictive covenant? _____ If yes, for _____ years, in a radius of ___ miles from this address: _____

How long have you been looking for an associate position? _____ What factors have prevented you from locating one acceptable to you? _____

_____

EXPERIENCE / HISTORY:

Dental school attended: _____ Date graduated: _____ Residency or specialty training programs: (__) Yes (__) No --If yes, describe: _____ Date completed: _____

Date obtained dental license for state in which are desire to find an associate position: _____

Months or years experience clinical dentistry? _____

Where are you working now? _____ Are you currently an owner, associate or partner? _____ How long have you worked there? _____ How much dentistry do you currently produce per month? $_____ Your current annual income is: $_____

Why would you like to leave your current position? _____

_____

If patient treatment needs were available, what is the upper limit of dentistry that you feel you could produce each month? $_____ What currently limits your production? _____

Do you have a history of late payments, credit problems, or bankruptcy that could effect your ability to obtain financing for the eventual purchase of a practice? _____

Do you have any past dental board orders, actions, cases, or investigations? (__) Yes (__) No If yes, please explain the circumstances, the status, and resolution if presently resolved (Attach another sheet if needed for full explanation) . _____

_____

_____

_____

If you have a resume prepared, please include a copy when you return this questionnaire.

Your Signature:_____**Date:** _____

Return This Questionnaire By Mail or Fax To:

George D. Stollings & Associates, Inc.

Mail: **194 Davis Branch Road**
Prichard, WV 25555 - 7511

Fax: **(304) 486-5815**

Contact Us If You Have Questions

E-mail: george@gdstollingsassoc.com

PH: (304) 486-5714