Fill out the form below completely. All receipts should be attached to the form and emailed to [info@smilenorthdakota.org](mailto:info@smilenorthdakota.org).

|  |  |
| --- | --- |
| Date: |  |
| Name (First / Last): |  |
| Address: |  |
| City, State, Zip: |  |
| Phone: |  |
| Email: |  |
| Dental Practice Name: |  |
| Site Visit Name: |  |
| ND License #: |  |

|  |  |  |
| --- | --- | --- |
| Description of Reimbursement (date must be after 5/1/18) |  | Amount |
| DANB Test (enter date taken:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) |  |  |
| DANB/Dale Foundation Review Materials: (max. $400) |  |  |
| High School Visit / Career Fairs (pre-approval required): |  |  |
| Location: |  |  |
| Date: |  |  |
| Other: |  |  |
| Total |  |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Office Use Only | | | | | |
| Check Number |  | Amount |  | Date |  |