Smile FOR A Lifetime Foundation
smiling faces through braces

Helpful guidelines in applying for braces through Smile for a Lifetime Foundation:

- Applicant questionnaire must be handwritten and answered by the applicant.
- Applicant must have a significant aesthetic need for braces.
- *Applicant must demonstrate financial need.
- Applicant must be between 11 to 16 years old (For further questions please contact your local Smile for a Lifetime Chapter)
- Applicant must be a currently enrolled student
- Applicant should demonstrate a positive attitude
- Applicant must agree to follow the treatment plan and demonstrate the ability and commitment to make all appointments on time
- Applicant is encouraged to display involvement and leadership in extracurricular activities
- Must be willing during the treatment period to "pay it forward" by completing10 hours of community service
- **Two Letters of Recommendation are mandatory.** Please do not submit more than two letters, and limit each reference letter to one page each. Please type or print clearly with black ink (no pencil). Letters of Recommendation may be written by anyone- family, friends, teachers/coaches, counselors, dentists, etc.
- A clear **5x7 head shot with full smile & teeth showing must be included** with application.
- The application, letters of reference and pictures will not be returned and will become property of Smile for a Lifetime Foundation.
- Applications will be reviewed every two months.Application will be received on an ongoing basis. Each applicant will be notified of approval or denial after the end of each selection process.
- Return the completed application, applicant questionnaire, dentist recommendation letters of recommendation and photo together in one packet to:

Katie Doyle, Executive Director
Treatment Coordinator
Wall Orthodontics
1512 Brampton Avenue
Statesboro, GA 30458

Questions:
katie@statesborobraces.com **or 912-764-6737**

**Applicants who qualify and are accepted for treatment may be required to submit proof of income i.e. W-2 (s), copy of income tax return, copy of past 3 pay stubs and/or other sources of income.*
****Applications that do not meet these criteria will be considered incomplete and will not be voted on by our Board of Directors.*

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THE GIFT OF SMILES

WALL ORTHODONTICS SMILE FOR A LIFETIME

Application Form

Please check the box indicating each additional piece of information is included:

[ ] General Dentist Form [ ] Two Letters of Reference [ ] Copy of Report Card or Transcript
[ ] Headshot [ ] Applicant Questionaire

Applicant Information

Applicant's Name: _____ Age: _____ DOB: _____ M/F
School Name: _____ Current GPA: _____ Average GPA: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Email: _____ Phone: _____
Name of Dentist: _____ Date of Last Visit: _____
Is the applicant of special needs or require special medical care? (Circle One) [ ] Yes [ ] No
If yes, please provide additional information: _____

Has the applicant received prior orthodontic serves? (Circle One) [ ] Yes [ ] No
If yes, please name the Dr who gave care and what services: _____

# of times applicant applied to Smile for a Lifetime: _____

Parent/Guardian Information

1. Parent/Guardian Name: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Email: _____ Phone: _____
Employer: _____ Work Phone: _____
Average Income: _____ # of Family Members: _____
2. Parent/Guardian Name: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Email: _____ Phone: _____
Employer: _____ Work Phone: _____
Average Income: _____ # of Family Members: _____

References:

1. Name _____ Phone: _____
1. Name _____ Phone: _____

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Applicant Questionnaire

Applicant Questionnaire must be handwritten and answered by applicant only. Questionnaires that are submitted and completed by someone other than the applicant will be disqualified.

1) What would it mean to you if you received orthodontic treatment through Smile For A Lifetime? Why do you feel you are a deserving candidate for Smile for a Lifetime?

2) Tell us about yourself. What do you like to do? What extracurricular activities do you participate in? Do you do any community service or volunteer work? What are your goals and aspirations?

3) Tell us about your family. How many people live with you and who are they?

4) Why do you want braces? What prevents you from getting braces now? How do you feel about your smile now? How do you think braces will improve your life now and in the future?

If you had a chance to do a favor for another person/organization, without any expectation of being paid back, what would you do and why?

If you need more space, please add up to one additional sheet of paper. Thank you.

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GENERAL DENTIST FORM

This form is to be completed by the applicant's general dentist and/or hygienist

OR

[ ] If you do not have a general dentist please check this box and leave form blank

Date: _____

Applicant's Name: _____

Applicant's Date of Birth: _____

General Dentist: _____

Office Phone: _____

Date of last dental cleaning & exam: _____

Please list any restorative work that needs to be completed:

_____

_____

_____

_____

Please Check One:

_____ Patient has received a cleaning and is cavity free.

_____ Patient has received all restorative treatment including a cleaning with exam & no additiona

_____ Patient has received cleaning with exam & restorative treatment has been scheduled.

Scheduled dates the restorative treatment is to be completed:

_____

_____

_____

Signature of Dentist/Hygienist