Rhode Island Mission of Mercy
Free Dental Clinic

Rhode Island Oral Health Foundation
1438 Park Avenue │Woonsocket│
Rhode Island│02895
rioralhealthfoundation.mom@gmail.com
www.RIMOM.org

Applicant Non Compensation Form

_____
Date

_____
Name

_____ _____
Home Address Work Address

_____ _____
City, State, Zip City, State, Zip

_____ _____
Social Security Number Date of Birth

_____
Dental Education

I certify that I will receive no compensation for any dentistry or dental hygiene services from the Rhode Island Oral Health Foundation rendered in Rhode Island while I am in the possession of a volunteer dental permit.

_____
Signature

State of _____

County of _____

On this, the_____ day of _____, 2023, before me a notary public, the undersigned officer, personally appeared _____, known to me (or satisfactorily proven) to be the person whose name is subscribed to the within instrument, and acknowledged that he executed the same for the purposes therein contained.

In witness hereof, I hereunto set my hand and official seal.

_____
Notary Public

RI ORAL HEALTH FOUNDATION
1438 PARK AVENUE

WOONSOCKET RI 02895

401 762 3044 401 769 0603