



Dr. Chad F. Harrington DDS, MSD

Application

Applicant Name: _____

Parents' Name: _____

Address: _____

Parent/guardian/applicant e-mail address: _____

Responsible party phone numbers: Home: _____ Cell: _____

Submitted by (circle one): Self Parent School Counselor Dentist Other _____

The applicant is an excellent candidate for Smile for a Lifetime because (please limit answer to space provided):

of times applicant has submitted an application to Smile for a Lifetime: _____ Applicant age: _____ Applicant sex: _____

Applicant grade: _____ Household income: _____

Parent/guardian place of employment: _____

Do applicants qualify for Medicaid/Medicare?: _____ Is applicant covered by dental insurance? _____

(specify company and policy #): _____

- You must submit a 5 X 7 **head-shot** photo of applicant with **full smile and teeth showing**.
- You must have two letters of reference (typed and limit each to one page each).

Please mail completed form with picture and reference letters to:

Harrington Orthodontics
Smile for a Lifetime Foundation
350 S. Columbia
South Bend, IN 46601

For questions: 574-233-7444
S4L@harringtonorthodontics.com

Candidates chosen for screening will be asked to provide verification of family income which may include a copy of last year's tax return, W-2, or a copy of the most recent pay stubs insuring Smile for a Lifetime that financial requirements are met. All applications, pictures and supporting documents will **not** be returned and become property of Smile for a Lifetime Foundation.