If you would like to nominate a dentist and/or dental office to join our network, please complete the following information.

**Dentist Name:** ________________________________

**Practice Name:** ______________________________

**Dentist Address:** ______________________________

City: __________________ State: ______ Zip: _____

**Dentist Phone Number:** ______________________________

**Your Name: (optional)** ______________________________

**Your Phone Number:** ______________________________

Please fax the completed form to 240-632-8187, Attn: Network Recruitment or e-mail it to us at networkrecruit@dbp.com.

One of our Dental Recruiters will contact the dental office to see if they would like to join our network of participating providers. Please allow 4-6 weeks for recruitment efforts to be completed.

Thank you for your nomination.