VERMONT STATE DENTAL SOCIETY
PATIENT REQUEST FOR MEDIATION

Upon receipt of this completed form, a mediator will be assigned and will contact you within 25 days to discuss your request and help resolve the issue. While a refund of the charges you have paid is one of the options that may be recommended by the mediator, a request for a refund should not be made in writing or on this form.

Patient Information:

Date_____ Case # _____

Name_____ Tel._____

Address_____

City _____ State _____ Zip_____

Name of Dentist:_____

Tel. _____ Address _____

_____

Date of last appointment _____

Please describe the problem(s) specific to the dental treatment received:_____

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Please complete reverse side

Thank you for addressing your concerns to the VERMONT STATE DENTAL SOCIETY.

Please provide below a phone number and the best time of day when the mediator will be able to contact you. If you have any questions in the meantime, do not hesitate to contact the VERMONT STATE DENTAL SOCIETY 802/864-0115 or 1-800-640-5099.

Day Phone _____ Time: _____

Evening Phone_____ Time: _____

In order that a complete review be performed, I authorize the release to this committee of any dental records or information by anyone who has examined me previously. I further give my permission for the committee to perform a clinical examination if necessary.

Signature _____

Please return this form to: VERMONT STATE DENTAL SOCIETY
100 DORSET STREET, SUITE 18
SOUTH BURLINGTON, VT 05403