



Smile for a Lifetime  
**Dr. Robert B. Campbell and Dr. Thomas Covington**  
1516 Doctors Circle | Wilmington, NC 28401

**Smile for a Lifetime Mission:**

Our mission is to **create self confidence, inspire hope, and change the lives** of children in our community in a dramatic way. The gift of a smile can do all this for a deserving, under-served child who, in turn, can use this gift to better themselves and our community.

- You must submit two 5 x 7 photos of the applicant. One photo should be a headshot showing a full smile and the other should show only the applicant's teeth. Both photos should be **FOCUSED**.
- You must have two reference pages completed by a teacher, guidance counselor or another adult.
- Include a copy of the applicant's last report card or school transcript.

Applicant's Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Grade: \_\_\_\_\_

Name of Parent/Guardian: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ E-Mail: \_\_\_\_\_

Parent/Guardian Employment: \_\_\_\_\_

Is the Applicant covered by dental insurance? \_\_\_\_\_ Does Applicant qualify for government assistance: \_\_\_\_\_  
(The answers to these questions have no bearing on the awarding of the Smile for a Lifetime Scholarship.)

Annual Household Income: \_\_\_\_\_ Number of people living in your household \_\_\_\_\_ **Please be prepared to show a copy of last year's tax return, W-2s, or a copy of recent pay stubs for all family wage earners.**

Do you have reliable transportation? \_\_\_\_\_ Do you believe that you could be present for 15-20 scheduled appointments at Campbell & Covington Orthodontics without difficulty? \_\_\_\_\_

School Attendance Record (Year to Date): Days Absent \_\_\_\_\_ Days Tardy \_\_\_\_\_

How did you hear about Smile for a Lifetime? \_\_\_\_\_

E-mail address for Submitter: \_\_\_\_\_ Phone: \_\_\_\_\_

Please mail completed application with pictures, reference pages & questionnaire to:  
Campbell & Covington Orthodontics Smile for a Lifetime Chapter  
Attn: Smile for a Lifetime Board of Directors  
1516 Doctors Circle | Wilmington, NC 28401  
Questions: smileforalifetime@gmail.com

All applications, pictures and supporting documents will NOT be returned and become property of Smile for a Lifetime foundation.

Smile for a Lifetime

Page II

Applicant Questionnaire:

1. Tell us about yourself. What are your interests and hobbies? In what extracurricular activities are you involved? Do you participate in any community service or volunteer projects? What are your goals for your future?
2. Tell us about your family. How many people live with you, and who are they?
3. Why do you want braces? How do you feel about your smile now? How do you think braces could improve your life now and in the future?
4. If you had a chance to help others, would you? If so, list the ways that you'd like to assist others.

Signature of Parent or Legal Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Smile for a Lifetime, Wilmington and Tri-County Chapter  
Reference Page, Page III

The Smile for a Lifetime Board of Directors would like to thank you for taking the time to complete the following reference page on behalf of the Smile for a Lifetime applicant. This information will help our board to award a deserving child with a new smile. **Please feel free to use the back of this form should your responses not fit in the spaces provided.**

How long have you known the applicant? \_\_\_\_\_

What is your relationship to the applicant? \_\_\_\_\_

Please address the potential benefits of orthodontia to the candidate.

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Please address the character of the applicant in terms of his/her dedication to his/her education, community and family.

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Are you aware of any limitations of the applicant of attending regular appointments over an extended treatment regime?

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The Applicant is an excellent candidate for a Smile for a Lifetime Orthodontic Scholarship because:

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We may need to contact you should we have further questions. Please provide us with your name and a contact phone number or email address. Thank you for supporting Smile for a Lifetime!

Name: \_\_\_\_\_ Contact Information: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Smile for a Lifetime, Wilmington and Tri-County Chapter  
Reference Page, Page IV

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We may need to contact you should we have further questions. Please provide us with your name and a contact phone number or email address. Thank you for supporting Smile for a Lifetime!

Name: \_\_\_\_\_ Contact Information: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**AUTHORIZATION FOR SMILE FOR A LIFETIME, INC.,**  
**CAMPBELL & COVINGTON ORTHODONTICS**  
**TO RELEASE NAME, PHOTOGRAPHS, FILMS AND "PHI" TO MEDIA OUTLETS**  
**AND SIMILAR PUBLICATIONS**

The undersigned hereby authorizes Smile for a Lifetime, Inc., Campbell & Covington Orthodontics, Dr. Robert B. Campbell and Dr. Thomas Covington to release photograph(s), film, and information regarding the patient's treatment, including Protected Health Information ("PHI") pursuant to 45 C.F.R. §164.508(a)(3), for the limited purpose of its newsworthiness to the general public, or for human interest, publicity, marketing and/or advertising, concerning:

Patient's Name: \_\_\_\_\_

These records may be used for promotional or publicity purposes and may appear in mass media publications, on the Smile for a Lifetime, Inc. or Campbell & Covington Orthodontics internet sites, within other such publications or on similar internet sites, shown in television presentations, and released to media outlets. The patient and/or his/her legal representative agree that the patient's identification including the patient's and family's name may be used in such release(s). This release may be revoked by the patient and/or his/her legal representative at any time, in writing. Such revocation shall only be effective to prevent any expanded future use of the information from the date of revocation of said consent. Otherwise, this release shall continue without expiration. The patient and/or his/her legal representative acknowledge that participation in or treatment under the program, Smile for a Lifetime, is not conditioned upon agreeing to sign this release. The patient and/or his/her legal representative also acknowledge that PHI and other information, photographs, films, and the like used for the purposes sought by this release could be disclosed by others who view it and that the PHI may no longer be protected by 45 C.F.R. §164.508(a)(3). Finally, the patient and/or his/her legal representative acknowledge that they have been provided a copy of the signed release regarding these disclosures.

I/we understand and acknowledge the forgoing. All questions regarding the requested disclosures have been answered and I/we voluntarily agree to the disclosures outlined above without limitation.

Signed (Patient, or Parent or Legal Guardian if Patient is a Minor):

\_\_\_\_\_  
Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Witness: \_\_\_\_\_

This \_\_ day of \_\_\_\_\_, 20\_\_

The Wilmington Smile for a Lifetime Board of Directors will carefully evaluate each application.  
It is important for all applicants to remember that some oral issues involving genetic  
or developmental problems and/or requiring surgical intervention  
may be beyond the scope of this program.