TMJ & Sleep Therapy Centres
INTERNATIONAL

TMJSTC INQUIRY APPLICATION

Date: ____________________

Name: ____

Phone Number: ____________________________________

Email Address: ____________________________________

What peaked your interest in becoming a TMJ & Sleep Therapy Centre?

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Number of years as a dentist: ______________________

Practicing area and desired location: ______________________

What percentage of your practice is treating TMD, Craniofacial Pain/Sleep? ______

Short and long term goals and income expectations:

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How may other dentists in your county market themselves for TMJ/Sleep Tx:

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Level of experience in treating Craniofacial Pain / TMD and Sleep:

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Certifications: ____________________________________

Number of hours CE in Craniofacial/Orofacial Pain and Sleep: ____________

Equipment available: ______________________________

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