Practice Protection Plan **Instruction Sheet**

1. Execute the *Letter of Authorization (LOA)* to follow below.

2. Deliver the executed *LOA* to a trusted individual (attorney, executor/rix, spouse, family member, etc.) and instruct that individual to immediately forward it to Choice Transitions, LLC upon your untimely death or disability of incompetence in nature. The original must be mailed to our corporate headquarters, however a faxed or email copy will suffice initially to begin the process until the original is received. Note, in the event the *LOA* is lost or destroyed at the time of your demise, a letter of authorization by your legal authorized representative will suffice.

3. Execute the *Limited Listing Agreement* to follow below and return to Choice Transitions, LLC along with the requested materials therein you are able to generate. The executed Agreement and all materials provided, both initially and annually thereafter, will be held in escrow, and will be kept strictly confidential.

Letter of Authorization

This *Letter of Authorization,* executed by me on the date below, is intended to be held in trust, in full effect, until such time of my demise or mental incompetence; at which time is to be immediately released and forwarded to Choice Transitions, LLC ("CHOICE").

This Letter hereby authorizes Choice to begin the immediate marketing and sale of my dental practice located at (Practice Address)

_____ pursuant to the terms and conditions as set forth in the Limited Listing Agreement For Brokerage Services fully executed by me on _____ _____.

Executed this ____ day of _____, 20___.

_____ _____

Print Name Signature

STATE/COMMONWEALTH OF _____

COUNTY _____

Then personally appeared before me the above-named _____**,** and acknowledged execution of the foregoing instrument to be the free act and deed of the Individual/Corporation.

_____

Notary Public
My commission expires:

LIMITED LISTING AGREEMENT FOR BROKERAGE SERVICES

AS A RESULT OF TRAGEDY

Agreement made this ____ day of _____ 20__, by and between _____ _____ with a dental office located at _____ _____ (hereinafter referred to as the "Owner") and CHOICE TRANSITIONS, LLC, a Rhode Island Limited Liability Company with a principal place of business at 200 Centerville Road, Suite 8, Warwick, Rhode Island 02886 (hereinafter referred to as "CHOICE").

1) Exclusive Right To Market/Sell. In consideration of the promise of CHOICE to market and use its best efforts to sell the dental practice located at the above address in the event of owner's death or disability (hereinafter referred to as the "Practice" or "Practice Location"), the Owner hereby grants CHOICE the exclusive right to list, market, offer for sale and to sell the Practice through its best efforts.

2) Term. This Agreement shall take effect **ONLY** upon CHOICE's receipt of either: (i.) the pre-executed Letter of Notification by Owner authorizing CHOICE to begin immediate marketing of the practice as a result of Owner's death or disability; or (ii.) in lieu of the pre-executed Letter of Notification due to loss or destruction, an executed letter authorizing CHOICE to begin immediate marketing of the practice, which shall be in accordance with the terms of this Agreement, by an authorized individual. Once in effect, this Agreement shall remain in force for a period of three (3) months from the date specified above. Upon expiration of the three (3) months, this Agreement shall automatically renew on a month-to-month basis until either party notifies the other party with at least sixty (60) days notice in writing of its intention to terminate.

3) Authority of CHOICE. During the term of this Agreement, CHOICE is granted sole authority to market and advertise the Practice for sale and to take all steps necessary to bring about a sale.

4) Duties of CHOICE. CHOICE shall make diligent efforts to effect a sale of the Practice and shall list and advertise it in such a manner, as it deems most likely to bring about a sale, and at CHOICE's sole expense.

5) Fees. CHOICE shall be entitled to a fee due and payable at the Closing equal to the greater of eight (8%) percent of the purchase price of the Practice; or Ten Thousand and xx/100 ($10,000.00) Dollars.

6) Representations.

(a) The Owner represents that at the time of execution of this Agreement, he/she/it is the Owner of the Practice and has full power and authority to execute this Agreement and engage in the transactions contemplated hereby.

(b) CHOICE makes no representations or guarantees of a sale.

(c) The Owner represents that all material and data concerning Owner's practice supplied to CHOICE each year shall be true and accurate; CHOICE may rely on the accuracy of the materials and data, and may furnish copies of the same to prospective buyers, and their advisors.

(d) Owner is responsible for forwarding to CHOICE all requested items necessary to market and sell the practice listed below. CHOICE can not be held liable for any delays in marketing the practice or bringing about the sale of the practice caused by Owner's failure to provide the necessary requested information.

(e) In performing the appraisal, CHOICE will be relying on the accuracy and reliability of your historical financial statements, forecasts of future operations, or other financial and practice related

data you will provide. We will not audit, compile, or review your financial information, statements, forecasts or other data you provide. We do not express an opinion or any form of assurance on them. The engagement of our services cannot be relied on to disclose errors, irregularities, or illegal acts, including fraud or embezzlements, which may exist.

7) Sale After Termination of Agreement. If a sale is consummated after termination of this Agreement to a party or on behalf of a party, to whom the dental practice was submitted either by CHOICE or current Owner during the term hereof, CHOICE will nevertheless be entitled to its full fee, pursuant to Paragraph 5 hereof.

8) Requested Information. Please provide the following initial information along with a completed questionnaire (**to be provided below**) to be stored in your file for purposes of preparing the appraisal and marketing your practice immediately upon this Agreement taking effect:

a. Copies of the business tax returns for the 3 previous years.

b. Equipment list and depreciation schedules of the equipment, furniture, fixtures and any leasehold improvements. (Normally, your dental equipment rep will supply you with an independent equipment appraisal. This is the most accurate way of determining the equipment value. If this is not feasible, we can prepare said valuation of the equipment from our receipt of the equipment original costs and dates of purchase, adjusted for depreciation).

c. Copy of the practice lease, if renting. If real estate is owned, and for sale, please provide a copy of the commercial appraisal if performed.

d. A copy of your most recent fee schedule.

e. Production figures for each provider (year end), being the dentist's production, hygienist's production and any other associate working in the practice (if applicable) for the three most recent tax years.

f. A breakdown of the revenues of the practice according to procedures for the past 3 years.

g. A summary copy of your patient demographic report: Male/Female, age, zip codes, insurances, etc. (if available)

h. Summary of aged accounts receivable report.

i. A copy of the w2's and/or 1099's for all staff for the previous 3 years.

j. Breakdown of all insurances paid by practice (i.e. malpractice, overhead, medical/health, life, disability, etc); more specifically amount paid for owner's benefits vs. amount paid for staff.

k. Pension contribution report or breakdown, if applicable, more specifically amount paid to owner's pension vs. amount paid to staff by practice (not staff contribution).

l. Digital or hard copy photos of the interior and exterior of the practice.

Additionally, please forward to us each succeeding year the following:

a. Prior year's tax return, w2's, 1099's.

b. Any additional equipment purchases along with the cost of such.

c. Copy of prior years production reports, collection reports, and fee schedule (if modified).

d. Any significant updates to the initial Practice questionnaire such as change in staff, hours, participating insurances, etc.

9) Miscellaneous.

(a) In the event the Fee referred to in paragraph 5(b) hereof is not paid at the Closing interest shall accrue at a rate of 12% per annum, daily from the due date of the fee.

(b) In the event CHOICE refers the collection of the fee to another, Owner shall pay the costs of collection, including reasonable attorney fees.

(c) Upon sale of the Practice, Owner hereby consents to CHOICE's use of Owner's and/or the Practice name as part of its marketing campaigns.

10) Counterparts. This Agreement has been executed in one or more counterparts and each shall be deemed to be an original and shall be binding upon and inure to the benefit of the heirs, administrators, executors, successors and assigns of the respective parties hereto.

11) Arbitration. Any and all disputes arising under this Agreement shall be exclusively resolved by the American Arbitration Association and in accordance with their rules whose decision shall be final and binding. The prevailing party shall be entitled to recover reasonable legal fees. Both parties will share the cost equally of filing the petition.

12) Indemnification. Owner agrees that he/she shall be responsible and liable, and further agrees to indemnify and hold CHOICE harmless for and to defend against any and all claims and liabilities arising in connection with the Practice financial or statistical information or representation provided by Owner to CHOICE or potential Buyer/Associate, either verbally or in writing, in the marketing and sale of Owner's Practice whether such action occurs prior to or following the sale of the Practice.

IN WITNESS WHEREOF, the parties have hereunto executed this Agreement on the date first written above. In the event that more than one date appears, the latest date shall be the execution date.

WITNESS: OWNER OF PRACTICE

_____ _____

(Print Name)

CHOICE TRANSITIONS, LLC (CHOICE)

_____ _____

By:
MEMBER

Choice Transitions, LLC

[Personal Information Sheet – Internal Use Only]

Please provide us your personal information for internal use and confidential correspondence. Your personal **Residence** information will remain unavailable to prospects.

Residence:

Name: _____ ❍ DMD/ ❍ DDS

Street Address:_____

City/Town: _____ State: _____ Zip Code: _____

Telephone #'s: *Home:* _____ *Cell:* _____ *Fax:* _____

Personal Email: _____

Please answer the following:

Practice Litigation/Claims:	❍ *Past*	❍ *Active/Pending*	❍ *None*
Criminal Charges/Convictions:	❍ *Past*	❍ *Active/Pending*	❍ *None*
Dental License Suspended/Revoked:	❍ *Past*	❍ *Active/Pending*	❍ *None*
Bankruptcy:	❍ *Past*	❍ *Active/Pending*	❍ *None*

If yes to any of the above, or any other circumstances that may affect a sale, please explain:

_____

_____

_____

_____

_____

Have you listed the Practice for sale in the past? _____ If yes, with whom & when? _____

_____

The following pages are the questionnaire which request Practice information for the file including the office telephone number and fax. Please check the appropriate response:

❍ ***Please do <u>NOT</u> contact the office*** ❍ ***You <u>MAY</u> contact me at the office***

Choice Transitions, LLC

PRACTICE QUESTIONNAIRE

Section 1: Personal Information

Please complete this **confidential** questionnaire. The information you provide will assist us in both the appraisal and marketing of your Practice. Please try to complete the questionnaire as accurately as possible.

Owner's Name: _____ ❍ DMD/❍ DDS/❍N/A

Dental School: _____ Year of Graduation: _____

D.O.B. _____ Spouse's Name: _____

Section 2: Practice Legal Name/Information

Primary Facility:

Legal Practice Name: _____

Practice Street Address: _____

City/Town: _____ State: _____ Zip Code: _____

Office Phone: _____ Fax: _____ Practice County: _____

Type of Entity: ❍ *Sole Practitioner* ❍ *LLC* ❍ *Corporation* ❍ *Partnership*

Associate(s) Name: _____

If Associate(s), is he/she under a contract with a restrictive covenant? _____

Partner(s) Name: _____

Percent Ownership: You:_____% Partner#1:_____% Partner #2:_____%

Type of Practice: ❍ *General Dentistry* ❍ *Specialty Practice:* _____

If Specialty, area of special interest: _____

Years Practicing: _____ Years at Current Location: _____

If less than 5 years at current location, former address: _____

Section 3: PRIMARY Facility
(Additional pages to follow for additional locations)

Primary Facility:

❍ *Office Complex* ❍ *Free Standing Building* ❍ *Home Office* ❍ *Storefront/Retail Building*

❍ *Other*_____ Size of office: _____sq./ft.

Is there room for expansion? ❍ *Yes* ❍ *No*

Is office handicap accessible? ❍ *Yes* ❍ *No*

Is there on-site parking? ❍ *Yes* ❍ *No*

*(If Yes, please describe location & # of spaces)*_____

_____

The real estate is: ❍ *Owned* ❍ *Leased*

If Leased*:*

Landlord: _____

What is the monthly rent? $_____/month *Expires*:_____

Included in rent (i.e. utilities, taxes)? _____

Option to renew? ❍ *Yes (how long_____)* ❍ *No*

Do you have the right to Assign? ❍ *Yes* ❍ *No*

Average monthly cost of utilities? $_____/month

Approximate value of leasehold improvements: $_____

If Owned*:*

Are you willing to rent/lease? ❍ *Yes* ❍ *No*

Monthly Rent Expected: $_____

Included in rent (i.e. utilities, taxes)? _____

Are you willing to sell the real estate? ❍ *Yes* ❍ *No*

Approximate Fair Market Value: $_____

Section 3 Continued: PRIMARY Facility

Description of Office: (*Please state number of each)*

Reception Area	_____	Business Office	_____
Consultation Room	_____	Operatories	_____
Laboratory	_____	Utility Room	_____
Sterilization	_____	Dark Room	_____
X-Ray Units	_____	Lavatories	_____
Staff Lounge	_____	Storage	_____
Other:	_____		

Office Equipment: *(Check all that apply)*

❍ Intra Oral Camera	❍ Panorex	❍ Defibrillator	❍ Air Abrasion
❍ Laser	❍ Compressor	❍ Digital Radiography	❍ Nitrous Oxide
❍ Vacuum	❍ Patient Education	❍ Cerec	Other ❍ _____

The equipment is: ❍ *Right-handed* ❍ *Left-handed* ❍ *Both*

Is the office computerized? ❍ ***Yes*** ❍ ***No*** *(skip to next page)*

When was the system purchased?	_____
Approximate cost of system when purchased:	$_____
When was the system upgraded? (if applic.)	_____
Approximate cost of system upgrade: (if applic.)	$_____
Type of dental software used?	_____
Are there computers in the operatories?	_____
Yearly cost for software contract?	$_____

[Skip this page if only one facility – Duplicate it if more than two locations]

Section 3 Continued - ADDITIONAL Facilities (If Applicable)

Facility 2:

Practice Street Address: _____

City/Town: _____ State: _____ Zip Code: _____

Office Phone: _____ Fax: _____ Practice County: _____

❍ *Office Complex* ❍ *Free Standing Building* ❍ *Home Office* ❍ *Storefront/Retail Building*

❍ *Other*_____ Size of office: _____sq./ft.

Is there room for expansion? ❍ *Yes* ❍ *No*

Is office handicap accessible? ❍ *Yes* ❍ *No*

Is there on-site parking? ❍ *Yes* ❍ *No*

*(If Yes, please describe location & # of spaces)*_____

_____

The real estate is: ❍ *Owned* ❍ *Leased*

If Leased*:*

Landlord: _____

What is the monthly rent? $_____/month *Expires*:_____

Included in rent (i.e. utilities, taxes)? _____

Option to renew? ❍ *Yes (how long_____)* ❍ *No*

Do you have the right to Assign? ❍ *Yes* ❍ *No*

Average monthly cost of utilities? $_____/month

Approximate value of leasehold improvements: $_____

If Owned*:*

Are you willing to rent/lease? ❍ *Yes* ❍ *No*

Monthly Rent Expected: $_____

Included in rent (i.e. utilities, taxes)? _____

Are you willing to sell the real estate? ❍ *Yes* ❍ *No*

Approximate Fair Market Value: $_____

[Skip this page if only one facility – Duplicate it if more than two locations]

Section 3 Continued - ADDITIONAL Facilities (If Applicable)

Description of Office: (*Please state number of each)*

Reception Area	_____	Business Office	_____
Consultation Room	_____	Operatories	_____
Laboratory	_____	Utility Room	_____
Sterilization	_____	Dark Room	_____
X-Ray Units	_____	Lavatories	_____
Staff Lounge	_____	Storage	_____
Other:	_____		

Office Equipment: *(Check all that apply)*

❍ Intra Oral Camera	❍ Panorex	❍ Defibrillator	❍ Air Abrasion
❍ Laser	❍ Compressor	❍ Digital Radiography	❍ Nitrous Oxide
❍ Vacuum	❍ Patient Education	❍ Cerec	Other ❍ _____

The equipment is: ❍ *Right-handed* ❍ *Left-handed* ❍ *Both*

Is the office computerized? ❍ ***Yes*** ❍ ***No*** *(skip to next page)*

When was the system purchased?	_____
Approximate cost of system when purchased:	$_____
When was the system upgraded? (if applic.)	_____
Approximate cost of system upgrade: (if applic.)	$_____
Type of dental software used?	_____
Are there computers in the operatories?	_____
Yearly cost for software contract?	$_____

Section 4: Demographics of Practice

(Please provide us with your opinion of the below information requested)

Practice location: ❍ *Urban/City* ❍ *Suburbs* ❍ *Rural*

Economic conditions where Practice is located: ❍ *Good* ❍ *Average* ❍ *Below Avg.*

Average income level of Patients: ❍ *Affluent* ❍ *Upper/Middle* ❍ *Middle* ❍ *Poor*

Please approximate geographical area that Practice draws patients: _____ miles

Please list the towns/cities where most patients reside: _____

Principal industries/employers near Practice: _____

Please tell anything else about the **city/town** where the Practice is located that will assist us in marketing your Practice (Industries/Activities/Awards/etc): _____

_____

_____

_____

_____

Source of new patients: *(approximate %)*

Patient referrals _____ *Professional referrals* _____

Advertising _____ *Other (i.e. walk-in)* _____

Type of advertising: *(please check all that apply)*

❍ *Yellow Pages* ❍ *Direct Mail* ❍ *Website* ❍ *Newspaper*

❍ *Other* _____

Section 5: Patient Base Information

Approximate number of **active** patients of the practice? _____

("Active patient" is a patient seen within last twelve - eighteen months)

Average number of **new** patients per month? _____

(This number should not include emergencies, unless patient becomes a permanent patient of practice)

Age of patient base: *(approximate %)*

❍ *Under 16* _____ ❍ *16 to 29* _____ ❍ *30 to 50* _____ ❍ *Over 50* _____

Where do patients come **from**: *(approximate %)*

Immediate community _____ *5-10 miles of practice* _____

10-20 miles of practice _____ *Beyond 20 mile radius* _____

Percent of patients **with** insurance: _____%

Percent of patients **without** insurance: _____%
(fee for service patients)

Does the practice participate with any type of state **welfare/assistance** plan? ❍ *Yes* ❍ *No*

If yes:

Percentage of insurance patients with **welfare/dental assistance**: _____%

Amount of total collections generated from **welfare/dental assistance:**

(Please write in 3 most previous years)

20__ Amount $_____

20__ Amount $_____

20__ Amount $_____

Section 6: Office and Practitioner Information

Average hours worked **per week** by: *Dentist* _____ *Hygienist(s)*_____

Average number of weeks worked **per year** by: *Dentist* _____ *Hygienist(s)*_____

Average number of patients treated **per day** by: *Dentist* _____ *Hygienist(s)*_____

List office hours:

Monday	_____	Thursday	_____
Tuesday	_____	Friday	_____
Wednesday	_____	Saturday	_____

Do you have a printed fee schedule? ❍ *Yes (please send copy)* ❍ *No*

If yes, when was fee schedule last updated? _____

Do you participate in any **PPO's or HMO's**? ❍ ***Yes*** *(please describe)* ❍ ***No***

_____

_____

Do you participate in any **DMO's**? ❍ ***Yes*** *(please describe)* ❍ ***No***

_____

_____

List all insurance plans you **participate** with: _____

_____

_____

List insurance plans you **accept** in addition to those above: _____

_____

_____

Section 6 Continued: Office and Practitioner Information

Type of dentistry produced: (*Please check all that apply)*

Estimate % of each of total production; ~OR~ if you refer out, please indicate so with an "R".

Operative/Restorative	_____	Endodontics	_____	Orthodontics	_____
Crown and Bridge	_____	Prosthodontics	_____	Periodontics	_____
Oral Surgery	_____	Cosmetic	_____	Preventive	_____
TMJ	_____	Other *(list)*	_____		

How many weeks in advance are appointments scheduled for? *Dentist* _____ *Hygienist(s)*_____

Describe hygiene recall system: _____

_____

_____

_____

What percentage of **gross income** is from? *Dentist* _____*%* *Hygienist(s)*_____*%*

Is the Practice compliant with **HIPAA** regulations? ❍ ***Yes*** ❍ ***No***

Is the Practice compliant with **OSHA** regulations? ❍ ***Yes*** ❍ ***No***

Have you **discussed** the potential sale of your Practice with staff? ❍ ***Yes*** ❍***No***

Which staff members do you expect would **remain** after a sale? _____

_____

Which staff members do you expect **will leave** after a sale? _____

_____

Section 6 Continued: Office and Practitioner Information

Please tell about your staff:

Name	Job Title	Date of Hire	Hrs / Wk	Hourly Wage or Current Salary

If any former staff was included in the wages (W2's or 1099's) for the past 3 years, please provide:

Name	Former Job Title	Termination Date	Hrs./Wk.	Hourly Wage or Salary

Section 7: Valuation Questions

In order for our valuators to properly assess the value of your dental Practice, we need to determine if some of the expenses you incurred were non-recurring or unnecessary for the continuation of the Practice. Conversely, there may be expenses for the new potential owner that you did not incur. Therefore, please answer the following questions as accurately as possible so our valuation reflects the true value of your Practice.

Important note: the following questions pertain to expenses paid by your Practice only. If you paid any of the expenses personally and they are not listed on your Practice tax return, DO NOT LIST SUCH EXPENSES HERE, as such would result in an inaccurate appraisal of your Practice.

For the last three tax years:

1) Did the **practice** participate in any type of retirement/pension plan?

❍ ***Yes*** *(Please answer #1(a)-(c) below)* ❍ ***No*** *(Skip to question #2)*

a) Please list the total Pension amount for **you** (non-staff related pension), paid *by the Practice,* for the three most previous tax years:

20__ Amount $_____

20__ Amount $_____

20__ Amount $_____

b) Please list the total Pension amount for **your spouse,** if applicable, (non-staff related pension) paid *by the Practice*, for the three most previous tax years:

20__ Amount $_____

20__ Amount $_____

20__ Amount $_____

c) Please list the total Pension amount paid for **staff** (not including the staff's own contributions) paid *by the Practice*, for the three most previous tax years:

20__ Amount $_____

20__ Amount $_____

20__ Amount $_____

Section 7 Continued: Valuation Questions

2) Did the **practice** participate in any type of health/medical insurance plan?

❍ ***Yes*** *(Please answer #2(a) & (b) below)* ❍ ***No*** *(Skip to question #3)*

a) Please list the total amount for **your individual or family** (non-staff related) health insurance paid *by the Practice,* for the three most previous tax years:

20__ Amount $_____

20__ Amount $_____

20__ Amount $_____

b) Please list the total amount for **staff's** health insurance (not including the staff's own contributions if any) paid *by the Practice* for the three most previous tax years:

20__ Amount $_____

20__ Amount $_____

20__ Amount $_____

3) Did you pay through the practice any **personal insurances** (i.e. disability, life, auto)?

❍ ***Yes*** *(please list amount for the three most previous tax years paid for each category)*

❍ ***No*** *(write N/A under each category)*

Any personal **life** insurance?

20__ Amount $_____

20__ Amount $_____

20__ Amount $_____

Personal **disability** insurance?

20__ Amount $_____

20__ Amount $_____

20__ Amount $_____

Any other **personal** insurance or expenses? *(Auto, real estate, etc)*

20__ Amount $_____ Expense description _____

20__ Amount $_____ Expense description _____

20__ Amount $_____ Expense description _____

Section 7 Continued: Valuation Questions

REAL ESTATE*:*

Many dentists own the real estate where the office is located. If so, those who do often have been advised by their accountants to pay themselves rent (often higher than fair market rent) or sometimes do not pay any rent at all. Whatever the case may be, our valuators will need to determine if rent is paid, and if the amount is more, less or about what the fair market rent would be to a new owner.

Therefore, if you own the real estate, answer the following questions:

4) Do you charge yourself rent for the office space? ❍ ***Yes*** *(Please list)* ❍ ***No*** *(skip to #6)*
(Please enter three most recent tax years)
20__ Amount $_____
20__ Amount $_____
20__ Amount $_____

5) Is the amount you paid yourself fair market rent? ❍ ***Yes*** ❍ ***No***
(what similar medical space would rent for nearby)

6) If you were to lease the dental space, please provide one of the following:

a) The total square footage and price per square foot you would expect to rent your office for:

_____ sq./ft. X $ _____ sq./ft.

---OR----

b) Monthly amount you expect to receive for rent: $_____

7) What will be included for the amount charged in #6 above (i.e. taxes, utilities, landscaping/snow removal, condo fees, etc.)?_____
_____

Note*:*
CHOICE will not audit or verify the amount you list in #4 above as fair market rent, and is relying on the accuracy of your answers in preparation of the appraisal of your practice. Therefore, the valuation CHOICE performs will be dependent upon what you determine in #4 or #6 above. Should you be uncertain, contact a local real estate agent for assistance.

Section 7 Continued: Valuation Questions

OFFICE STAFF NOTE*:*
Many dentists employ their spouses or other family members in the Practice, or alternatively, for tax and social security reasons, list a family member on payroll who is not actually working in the Practice. Therefore, in order for our valuators to accurately account for whatever the case may be, please answer the following questions:

8) Do you **employ or compensate** your spouse, children, or any other family member in your Practice?

❍ ***Yes*** *(Please answer #9 below)* ❍ ***No*** *(Skip to "Section Eight: Advisors")*

9) Please list the family member(s) you employ in your Practice and answer the questions thereafter:

a) Name #1:_____ Relationship:_____

Does he/she perform duties within the practice? ❍ ***Yes*** ❍ ***No***

If Yes, Job Title/Responsibilities: _____

Amount compensated per year: $ _____

Amount a non-family member would be compensated for same position: $_____

b) Name #1:_____ Relationship:_____

Does he/she perform duties within the practice? ❍ ***Yes*** ❍ ***No***

If Yes, Job Title/Responsibilities: _____

Amount compensated per year: $ _____

Amount a non-family member would be compensated for same position: $_____

c) Name #1:_____ Relationship:_____

Does he/she perform duties within the practice? ❍ ***Yes*** ❍ ***No***

If Yes, Job Title/Responsibilities: _____

Amount compensated per year: $ _____

Amount a non-family member would be compensated for same position: $_____

Section 8: Advisors

Accountant:_____ Phone: _____
Address: _____
Email: _____

Attorney:_____ Phone: _____
Address: _____
Email: _____

Other:_____ Phone: _____
Address: _____
Email: _____

If necessary, do we have your permission to **contact** your advisors? ❍***Yes*** ❍***No***

I have provided the information requested above and state that to the best of my knowledge, the information provided, regardless of who has completed this questionnaire (if not completed by owner themselves) is accurate and true and CHOICE is relying on the accuracy of such in preparation of the valuation of your dental practice and will not audit or verify the accuracy of the any information you provided in this questionnaire.

_____ _____
Owner ***Date***