ADA® MEMBERSHIP APPLICATION

Personal

☐ Dentist ☐ Dental Student ☐ Previous Member ☐ New Member

☐ Associate Member

ADA Number ☐☐☐☐☐☐☐☐☐

Social Security Number ☐☐☐☐☐☐☐☐☐

Name _____ Date of Birth _____

Office Address _____ Phone (___) _____

Home Address _____ Phone (___) _____

Mailing Address _____ Phone (___) _____

E-Mail _____ Fax (___) _____ Spouse's Name _____

Education

Dental Education _____ Graduation Date _____

Type of Degree ☐ D.D.S. ☐ D.M.D. Date of Specialty License _____

Specialty Board Certification _____ Date _____

License ☐ Presently ☐ Pending License# _____ State _____

Are you currently a full time student? ☐ Yes ☐ No Dental School _____

I hereby apply for membership in my local society, the Arkansas State Dental Association, and the American Dental Association, and resolve to abide by the Bylaws and Code of Ethics and Professional Conduct if accepted into membership.

Applicant's signature _____

Please return application to:

Arkansas State Dental Association
7480 Highway 107
Sherwood, Arkansas 72120

Office Use

Membership Information

Local Society $ _____

_____

District Name

ASDA $ _____

ADA $ _____

Student $ _____

TOTAL $ _____

1st year ___

2nd year ___

3rd year ___

4th year ___

5th year ___

ASDA Use Only

Application received _____

Received with application _____

Processed by _____

Member packet mailed _____

Sent to District _____

Returned _____

Component Use Only

☐ Elected

☐ Rejected

By Action _____

At a meeting _____

Secretary _____

Name of Society _____