



ADA[®] MEMBERSHIP APPLICATION

Personal

- Dentist
 Dental Student
 Previous Member
 New Member
 Associate Member

ADA Number _____

Male Female

Name _____ Birth Date _____

Office Address _____ Phone () _____

Home Address _____ Phone () _____

Mailing Address _____ Cell () _____

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

Education

Dental School _____ Graduation Date _____

Type of Degree D.D.S. D.M.D.

Graduate School _____ Graduation Date _____

Specialty Board Certification _____ Date of Speciality License _____

License Presently Pending License# _____ State: AR

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 _____ 1st year

2nd year _____

ADA _____ 3rd year _____

Student _____ 4th year _____

TOTAL _____ 5th year _____

ASDA Use Only

Application received _____

Received with application _____

Processed by Cheryl Ball _____

Member packet mailed _____

Sent to District _____

Returned _____

Component Use Only

Elected

Rejected

By Action _____

At a meeting _____

Secretary _____

Name of Society _____