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 _____

ADA _____

Student _____

TOTAL _____

1st year ___x
2nd year ___
3rd year ___
4th year ___
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 _____

7480 Highway 107 • Sherwood, AR 72120 • Phone (501) 834-7650 Fax (501) 834-7657 Toll Free (800) 501-2732