Tripartite Membership Application

For membership in the American Dental Association and your state and local dental societies

florida dental ASSOCIATION

ADA American Dental Association®
America's leading advocate for oral health

Please send your application to:
membership@floridadental.org or
Florida Dental Association
1111 E. Tennessee St.
Tallahassee, FL 32308

Thank you for your interest in becoming a member of organized dentistry.

The American Dental Association and your state and local dental societies have a tripartite membership structure. Therefore, final approval of your application provides you with membership at all three levels of your professional associations: local, state and national. Your application will be processed and considered by your state or local society, which will provide you with additional information regarding their specific application procedures. Please apply to the society where you conduct or will conduct the major portion of your practice; your state or local society may request additional information. For complete information regarding the *Bylaws* and the *Principles of Ethics* and *Code of Professional Conduct* of the ADA which govern the professional conduct of members, please visit ADA.org/ethicsconduct. A list of state dental societies can be found at ADA.org/societydirectories.

Please complete all sections of this application. Print or type all information.

Personal Information

Name (First) (Last) (Middle)				☐ Male ☐ Female
ADA ID Number (if known)			Date of Birth (MM/DD/YYYY)	
Primary Office Address				Suite
City	State	Zip	Phone (include area code)	
Email Address			Fax (include area code)	
Home Address			Phone (include area code)	
City	State	Zip	Please indicate if you prefer to have mail sent to: ☐ Home ☐ Office	Please indicate if you prefer to have email sent to: ☐ Home ☐ Office
Email Address				
Spouse's Name (optional) (First) (Last) (Middle) (Alias/Previous/Maiden) Is spouse a dentist? ☐ Yes ☐ No				
If an ADA member encouraged you to join, please indicate:	Name			State

Biographical

Dental School	Country	Graduation Date (MM/DD/YYYY)
Advanced Education Program (if applicable)	Completion Date (MM/DD/YYYY)	Certificate/ Degree

Do you have a degree in an ADA recognized specialty? ☐ Yes ☐ No

If yes, which specialty?
☐ Endodontics ☐ Pediatric Dentistry ☐ Periodontics ☐ Public Health ☐ Prosthodontics ☐ Orthodontics and Dentofacial Orthopedics
☐ Oral & Maxillofacial Pathology ☐ Oral & Maxillofacial Radiology ☐ Oral & Maxillofacial Surgery

Is your practice limited to one of the above specialties? ☐ Yes ☐ No If yes, which specialty?

Some societies offer assistance in locating a practice situation.
Contact your local dental society for information regarding their services.

Please indicate if practicing in, or looking for:
☐ Solo ☐ Group ☐ Partnership ☐ Associateship ☐ Clinic ☐ Faculty ☐ Federal Dental Service
☐ Other:

If practicing in other than a solo practice, please indicate the group or practitioner's name and location.

Name		
Street		
City	State	Zip
Please indicate if licensed: ☐ Presently ☐ License pending	If licensed, please list license number(s), date, year and state(s). Please indicate specialty license information if applicable.	

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Personal Background

Have you ever been denied a dental license? ☐ Yes ☐ No	If yes, in which state:	If yes, why?
Have you ever had your license suspended or revoked? ☐ Yes ☐ No	If yes, in which state:	If yes, why?
Have you ever been censored, suspended or expelled by a dentally related organization (i.e. dental society)? ☐ Yes ☐ No	If yes, in which state:	If yes, why?
Have you ever been convicted of a felony or criminal offense, including driving under the influence of alcohol or drugs, but excluding minor traffic violations and parking tickets? (A conviction record will not automatically bar you from membership. Each application will be individually considered on its merits.) ☐ Yes ☐ No	If yes, please describe (include dates, offenses and penalties):	

Applicant Signature

I hereby apply for a tripartite membership in the American Dental Association and resolve to abide by the *Bylaws* and *Principals of Ethics and Code of Professional Conduct* if accepted into membership. If I have paid by credit card below*, my signature authorizes payment. Review the bylaws and code at ADA.org/ethicsconduct.

Signature	Date (MM/DD/YYYY)

Electronic Communication

The FDA and its affiliated entities and component/affiliate dental associations rely heavily on electronic communications to keep members informed about issues affecting their practice and opportunities for discounts and other member benefits. As a member, you will get electronic communications. If you do not wish to receive electronic communications, please indicate below.

❑ **Do not send emails.** ❑ **Do not send facsimiles.**

**Your society will contact you if payment is required. Do not send payment now.*

To Be Completed By Society:

Dues Section ONLINE	ADA	$
	Constituent	$
	Misc.	$
	Misc.	$
	Component	$
	Total Dues Owed	$

How to submit your application

- Simply print and complete the application and mail or fax to: **1111 E. Tennessee St.**
  Tallahassee, FL 32308-6914
  Fax: 850.201.5013

- Or you may fill out the form and email it to the FDA Membership Department. If you choose this method, please follow these simple steps:

1. **You will need to have Adobe Acrobat Version 8 or above installed. Version 11 is available for free at:** http://get.adobe.com/reader/

2. **Please save the form to your hard drive and attach the file to an email message. Send your application to this email address:** membership@floridadental.org

- Questions about your application or membership? Call our FDA Membership Services Number: 800.877.9922/850.681.3629