

# Membership Application

For membership in the American Dental Association and your state/local/district dental society (where applicable)



P.O. Box 215  
Manchester, ME 04351-0215  
T 207.622.7900 F 207.622.6210 medental.org

**ADA** American Dental Association®

America's leading advocate for oral health

Department of Membership Operations  
211 East Chicago Avenue, Chicago, Illinois 60611  
T 312.440.2607 800.621.8099 ADA.org

## Thank you for your interest in becoming a member.

The American Dental Association and your state and local/district (if applicable) 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/district, state and national. Your application will be processed and considered by your state or local/district 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/district 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.**

**You may also be able to apply online. Please check your state dental society website for instructions.**

## Personal Information

Name (First)		(Last)		(Middle)		<input type="checkbox"/> Male <input type="checkbox"/> Female		
ADA ID Number (optional)			Date of Birth (MM/DD/YYYY)		Website Address			
Primary Office Address						Suite		
City			State	Zip	Office Phone (include area code)			
Office Email					Fax (include area code)			
Home Address					Mobile Phone (include area code)			
City			State	Zip	Please indicate if you prefer to have mail sent to:		Please indicate if you prefer to have email sent to:	
Home Email					<input type="checkbox"/> Home <input type="checkbox"/> Office		<input type="checkbox"/> Home <input type="checkbox"/> Office	
Spouse's Name (optional)		(First)		(Last)		(Middle)		(Alias/Previous/Maiden)
Is spouse a dentist? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No						
If yes, which specialty?						
<input type="checkbox"/> Endodontics	<input type="checkbox"/> Pediatric Dentistry	<input type="checkbox"/> Periodontics	<input type="checkbox"/> Public Health	<input type="checkbox"/> Prosthodontics	<input type="checkbox"/> Orthodontics and Dentofacial Orthopedics	
<input type="checkbox"/> Oral & Maxillofacial Pathology		<input type="checkbox"/> Oral & Maxillofacial Radiology		<input type="checkbox"/> Oral & Maxillofacial Surgery		
Is your practice limited to one of the above specialties? <input type="checkbox"/> Yes <input type="checkbox"/> No				If yes, which specialty?		
<i>Some societies offer assistance in locating a practice situation.</i>						
<i>Contact your local dental society for information regarding their services.</i>						
Please indicate if practicing in, or looking for:						
<input type="checkbox"/> Solo	<input type="checkbox"/> Group	<input type="checkbox"/> Partnership	<input type="checkbox"/> Associateship	<input type="checkbox"/> Clinic	<input type="checkbox"/> Faculty	<input type="checkbox"/> Federal Dental Service
<input type="checkbox"/> 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: <input type="checkbox"/> Presently <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, in which state:	If yes, why?
Have you ever had your license suspended or revoked? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, in which state:	If yes, why?
Have you ever been censured, suspended or expelled by a dentally related organization (i.e. dental society)? <input type="checkbox"/> Yes <input type="checkbox"/> 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.) <input type="checkbox"/> Yes <input type="checkbox"/> 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](http://ADA.org/ethicsconduct).

Signature	Date (MM/DD/YYYY)
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\*Your society will contact you if payment is required. Do not send payment now.

## To Be Completed By Society:

<b>Constituent Society</b>	Date Received (MM/DD/YYYY)	Approval Name		
	Date Approved or Disapproved (MM/DD/YYYY)	Approval Signature		
<b>Component Society</b>	Date Received (MM/DD/YYYY)	Approval Name		
	Date Approved or Disapproved (MM/DD/YYYY)	Approval Signature		
<b>Dues Section</b>	ADA	\$	Method of Payment <input type="checkbox"/> Visa <input type="checkbox"/> MasterCard <input type="checkbox"/> American Express	
	Constituent	\$		
	Misc.	\$	Credit Card Number	
	Misc.	\$	Expiration Date (MM/YY)	Security Code
	Component	\$	Name on Credit Card	
	<b>Total Dues Owed</b>	\$		

Please submit your completed 2-page application to your state or local dental society. A listing of state dental societies is available on our website at [ADA.org](http://ADA.org) or you may contact the ADA Department of Membership Operations at 312.440.2607 for more information.

Membership in the ADA is based on the calendar year from January to December. ADA dues allocation to **JADA**, \$25.00, to **ADA News**, \$8.00, and is not deductible from the dues amount.

**United States Taxpayers** Please Note: The tax law prohibits taxpayers from deducting the expenses that they incur by engaging in lobbying, as defined in the law. Accordingly, only that portion of an associations' member's dues not attributable to lobbying activities remains deductible as an ordinary and necessary business expense. The law requires associations to provide their members with a reasonable estimate of the non-deductible percent of their dues attributable to lobbying activities. For 2018, 7.2% of a member's ADA dues are allocated to lobbying activities. Dues payments and contributions are not deductible as charitable contributions for federal income tax purposes.