ADA Membership Application

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

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

Department of Membership Operations
211 East Chicago Avenue, Chicago, IL 60611
T 312.440.2699 F 312.440.2898 ADA.org

☐ **Yes, please sign me up for membership with Team ADA!**

Thank you for your interest in organized dentistry. Complete this application for membership in the tripartite with the ADA and your state and local societies. Direct Membership in the ADA is also an option for dentists in the Federal Dental Services, full-time graduate students or those licensed dentists without an established practice location. For tripartite applicants, final approval of your application provides you with membership at all three levels of your professional associations: local, state and national. Your state or local society may request additional information. Access the *Bylaws* and the *Principles of Ethics and Code of Professional Conduct* of the ADA which govern the professional conduct of members at ADA.org/ethicsconduct. A list of state dental societies can be found at ADA.org/societydirectories.

Please complete all sections of this application. Print legibly.

Personal Information

ADA Number (if known) _____ Degree (*Required) ☐ D.M.D. ☐ D.D.S.

Name (*Required) _____
First Last Middle Alias/Previous/Maiden

Current Mailing Address

Street _____ Date of birth ____/____/____
MM DD YYYY

_____ Sex ☐ M ☐ F

Suite or Unit # _____ Cellular Phone (____) _____

City _____ Phone (____) _____

State/Zip/County _____

Permanent Email _____

Do you know your future mailing address? ☐ Yes ☐ No
If so, is it your ☐ Office ☐ Home ☐ School

Start Date for
New Address ____/____/____
MM DD YYYY

Street _____ Suite or Unit # _____

City _____ State/Zip/County _____

Phone (____) _____ Fax (____) _____ Email _____

If you know the state in which you'll be practicing, please note it here: _____

Biographical and Education

Dental school (*Required) _____ Graduation date (*Required) ____/____/____
MM DD YYYY

Have you been accepted into a full-time residency or advanced education program of not less than one academic year's duration? ☐ Yes ☐ No

If yes, please indicate:

School/Hospital _____ Address _____

City _____ State/Zip/County _____

Specialty: ☐ Endodontics ☐ Pediatric Dentistry ☐ Periodontics ☐ Public Health ☐ Prosthodontics ☐ Orthodontics and Dentofacial Orthopedics
☐ Oral & Maxillofacial Pathology ☐ Oral & Maxillofacial Radiology ☐ Oral & Maxillofacial Surgery ☐ Other _____

Program Start Date _____ Completion Date _____

Please indicate if licensed: ☐ Presently ☐ License pending _____

If licensed or license pending please provide license number and state _____

Membership (*Required)

☐ I would like to apply as a Tripartite member in this state (please list) _____.
Dues at the national level are $0 and many state and local societies also offer reduced dues.

OR

I would like to apply as a direct member to the ADA: ☐ Federal Dental Services ($0) *Please complete Military Service section on the back.*
☐ Graduate Student or FDS Graduate Student ($30)

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Personal Background (*Required)

Have you ever been denied a dental license? ☐ Yes ☐ No If yes, in what state? _____

If yes, why? _____

Have you ever had your license suspended or revoked? ☐ Yes ☐ No If yes, in what 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 what 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): _____

Military Service

If you are practicing or will be practicing in the Federal Dental Services, please indicate which branch:

☐ U.S. Air Force ☐ U.S. Army ☐ U.S. Navy ☐ U.S. Dept. of Veteran Affairs ☐ Other: _____

☐ U.S. Public Health Service Agency: _____

In-Service Date: _____ / _____ / _____
MM DD YYYY

Applicant Signature (*Required)

I hereby apply for membership in the American Dental Association and resolve to abide by the *Bylaws and Principles of Ethics and Code of Professional Conduct* if accepted into membership.

Signed _____ Date _____ / _____ / _____
MM DD YYYY

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

To Be Completed By Society

Constituent Society

Date received: _____ / _____ / _____
MM DD YYYY

Date approved or disapproved _____

Approval signature _____

Approval name _____

Component Society

Date received: _____ / _____ / _____
MM DD YYYY

Date approved or disapproved _____

Approval signature _____

Approval name _____

Dues Section

ADA ..... $ _____

Constituent ..... $ _____

Misc. ..... $ _____

Misc. ..... $ _____

Component ..... $ _____

Total Dues Owed ..... $ _____

Method of payment _____

Credit card number _____

Expiration date _____ / _____
MM YYYY

Name on credit card _____

Please complete the application and turn in at National Signing Day or mail to ADA.
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.

Code: Signing2015