TRIPARTITE MEMBERSHIP APPLICATION

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

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 dental 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 and will provide you with complete information regarding membership dues as well as the *Bylaws* and *Code of Professional Conduct* of the ADA and your state and local dental societies, which govern the professional conduct of members.

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

Name _____
last first middle

Degree: ❑ DMD ❑ DDS ❑ Other _____

PRIMARY OFFICE ADDRESS

Street _____

City _____

State/Zip/County _____

Phone (_____) _____

Fax (_____) _____

_____
ADA ID Number (if known)

_____
Email Address

_____
Birth Month/Day/Year

HOME ADDRESS

Street _____

City _____

State/Zip/County _____

Phone (_____) _____

Spouse Name _____

Sex: ❑ M ❑ F

Please indicate if you prefer to have mail sent to:
❑ Office ❑ Home

Is spouse a dentist? ❑ Yes ❑ No

Dental School _____ *Graduation Date _____
month/day/year

Advanced Education Program _____
school/hospital city/state

*Completion Date _____ Certificate/Degree _____
month/day/year

Program Area(s): ❑ Endo ❑ Pediatric ❑ Perio ❑ Public Health ❑ Prostho
❑ Ortho ❑ Oral Path ❑ Oral Surg ❑ General Practice ❑ Other _____

Is your practice limited to the above specialty? ❑ Yes ❑ No

Please indicate if: ❑ Currently practicing ❑ Full Time ❑ Part Time

Please indicate if practicing in: ❑ Solo ❑ Group ❑ Partnership ❑ Associateship
❑ Clinic ❑ Federal Dental Service ❑ Other _____
❑ Dental Faculty ❑ Full Time ❑ Part Time Name of Institution _____

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

Name _____ Address _____

Please indicate if licensed: ❑ Presently _____ ❑ License Pending
(provide copy) License number(s)/date/state(s) Please include specialty license info if applicable

Are/were you a member of the American Student Dental Association?

❑ Yes ❑ No If yes, from _____ to _____
year year

Please indicate your membership status in the American Dental Association:

❑ Current member in _____ with dues paid for the _____ membership year
state society year

❑ Was previously a member in _____ and _____ from _____ to _____
state society local society year year

**If you are a recent graduate, please send a copy of your graduation certificate with your application.*

Please return to: **Tennessee Dental Association**
660 Bakers Bridge Avenue, Suite 300
Franklin, TN 37067

TDA web 11.05