Tripartite Membership Application

(Please type or print with ball point pen and complete all sections.)

ADA #(if Known): ______________________ Date: ____________ Birth Month/Day/Year____________

Name:____ Gender: F ☐ M ☐

Last First Middle DDS DMD

Ethnic background (optional)
Caucasian ☐ Asian ☐
Native American ☐
African American ☐
Hispanic ☐

Home Address: ____

____

Home Phone: (_____)______________________________________

Social Security: ______________________________ Mail to: Office ☐ Home ☐

Spouse Name: ______________________________ Is spouse a dentist? Yes ☐ NO ☐

PRIMARY OFFICE

Address: ____

____

Phone: (______)__________________________ Fax: (______)__________________________

E-mail: ____

EDUCATION/SPECIALTY

Dental School: ______________________________ Year of Graduation: ____________

PostGrad/Residency: ________________________Certificate/Degree______ Year of Graduation: ______

Program Specialty (check one): Endo ☐ Pediatric ☐ Perio ☐ Public Health ☐ Prostho ☐ Ortho ☐

Oral Path ☐ Oral Surg ☐ Other ☐ Is your practice limited to the above specialty? Yes ☐ No ☐

Please send a copy of your specialty degree/diploma.

PRACTICE/LICENSURE

Is your practice incorporated? ☐ Yes ☐ No License Number: ______________________

License #(s)/date/state

MEMBERSHIP INFORMATION

Please indicate your membership status in the American Dental Association:

☐ Current member in ________________ with dues paid for the 20 ____ membership year

☐ Was previously a member in ______________________ and ______________________

(state society) (local society)

Have you ever had any disciplinary charges made, or any disciplinary actions taken, against you by any state dental association or state agency? Yes ☐ No ☐

Signature____

(OVER)

Membership Dues

American Dental Association: $____________________

Washington State Dental Association: $____________________

Dental Society: $____________________

Total Membership Dues: $____________________

METHOD OF PAYMENT:
Please make checks payable to the Washington State Dental Association and submit your payment along with all copies of your membership application.

Check ☐ Visa ☐ Mastercard ☐ AMEX ☐

Credit Card Number: ____________________ Expiration Date: ____/____/____

Card Holders Signature: ____________________

PLEASE SUBMIT YOUR COMPLETED APPLICATION TO THE ADDRESS BELOW ALONG WITH A VALID CREDIT CARD NUMBER, A CHECK OR MONEY ORDER MADE PAYABLE TO THE WSDA.

LOCAL SOCIETY

Society: THURSTON-MASON COUNTIES DENTAL SOCIETY

Address: PO BOX 12418 ; OLYMPIA, WA 98508

Telephone: (360)956-0828 Fax: (360)956-0825

SOCIETY USE

Received: ____________________

Election Date: ____________________

Secretary-Treasurer: ____________________

Executive Director: ____________________

Date DQAC Checked: ____________________

WSDA USE

Date Processed: ____________________

Congressional District: ____________________

Legislative District: ____________________

Staff: ____________________