

# 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](http://ADA.org/ethicsconduct). A list of state dental societies can be found at [ADA.org/societydirectories](http://ADA.org/societydirectories).

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

## Personal Information

Name (First)		(Last)		(Middle)		<input type="checkbox"/> Male <input type="checkbox"/> 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:		Please indicate if you prefer to have email sent to:	
Email Address				<input type="checkbox"/> Home <input type="checkbox"/> Office		<input type="checkbox"/> Home <input type="checkbox"/> Office	
Spouse's Name (optional)		(First)		(Last)		(Middle)	
Is spouse a dentist? <input type="checkbox"/> Yes <input type="checkbox"/> No		(Alias/Previous/Maiden)					
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. 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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## 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	\$
	<b>Total Dues Owed</b>	\$

## 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:
  - You will need to have Adobe Acrobat Version 8 or above installed. Version 11 is available for free at: <http://get.adobe.com/reader/>
  - 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](mailto:membership@floridadental.org)
- Questions about your application or membership? Call our FDA Membership Services Number: **800.877.9922/850.681.3629**