



TRIPARTITE MEMBERSHIP APPLICATION
For membership in the American Dental Association,
Idaho State Dental Association and local dental societies

Thank you for your interest in becoming a member of organized dentistry. The American Dental Association, Idaho State Dental Association 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.

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

PERSONAL

Name _____ Degree [] DMD [] DDS [] Other _____
First MI Last

PRIMARY OFFICE ADDRESS

Mailing Address _____ ADA # if known _____
Suite # _____ Social Security Number _____
City _____ Date of Birth _____
State/Zip _____ Sex [] M [] F

Street Address if different than mailing address:

_____ Please indicate if you prefer to have mail sent to:
[] Office [] Home

City/State/Zip _____
Phone (____) _____ Fax (____) _____ E-Mail _____

HOME MAILING ADDRESS

_____ Unit/Apt # _____

City/State/Zip _____

Phone (____) _____ Fax (____) _____ E-Mail _____

Spouse Name _____ Is spouse a dentist? [] Yes [] No
First MI Last

BIOGRAPHICAL

Dental School _____ Graduation Date ____/____/____
MM DD YYYY

Advanced Education Program _____

Completion Date ____/____/____ Certificate/Degree _____
MM DD YYYY

Do you have a degree or certificate in an ADA recognized Specialty? [] Yes [] No If yes, which specialty?

[] Endodontics [] Pediatric Dentistry [] Periodontics [] Public Health [] Prosthodontics [] Orthodontics

[] Oral & Maxillofacial Pathology [] Oral & Maxillofacial Radiology [] Oral & Maxillofacial Surgery

Is your practice limited to one of the above specialties? [] Yes [] No If yes, which specialty? _____

Practicing In [] Looking for []

[] Solo [] Group [] Partnership [] Associateship [] Clinic [] Faculty [] Federal Dental Service [] Other _____

BIOGRAPHICAL CONTINUED

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: Presently Pending _____

If licensed please list license number(s), date, year and state(s)

MEMBERSHIP

Are/were you a member of the American Student Dental Association? Yes No If yes, from _____ to _____

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 _____ from _____ to _____
State Society Year Year

APPLICANT SIGNATURE

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

Signed _____ Date _____



American
Dental
Association

Please send your application to the Idaho State Dental Association,
1220 W. Hays Street, Boise, ID 83702. Phone: (208) 343-7543; Fax
number (208) 343-0775.