

# 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 \_\_\_\_\_ Degree:  DMD  DDS  
last first middle  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