2019 TRIPARTITE APPLICATION FOR MEMBERSHIP IN THE LOCAL DISTRICT DENTAL SOCIETY, THE ALABAMA DENTAL ASSOCIATION AND THE AMERICAN DENTAL ASSOCIATION

Date ________________ **ADA#**________________________

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

Name ____ **Degree:**____DMD
Last First Middle ____DDS

Office Address
Street____
City____
State/Zip ____
Phone ( )____
Fax ( )____
E-mail ____

____
Birth Month/Date/Year

Sex:____M____F

Ala. License # _______

Home Address
Street____
City____
State/Zip____
Phone( )____
Spouse Name____
Is spouse a dentist? Yes No

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

Dental School____________________________________**Graduation Date** ______________

Advanced Education Program ____
School/Hospital City/State

Completion Date___________________________**Certificate/Degree**____________________

Program Area(s): Endodontics______Pediatric_____Periodontics______Public Health ______
Prosthodontics____Orthodontics_____Oral Surgery_____General Practice_____Other ______

Is your practice limited?_____**Yes**_____**No**

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Signature of Applicant

If an ALDA member encouraged you to join, please tell us whom we can thank:

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