



METROPOLITAN DENVER DENTAL SOCIETY

Connections For Our Profession

TRIPARTITE MEMBERSHIP APPLICATION

National – American Dental Association

State – Colorado Dental Association

Local – Metropolitan Denver Dental Society

PLEASE TYPE OR PRINT (Fields indicated in red are required)

Name _____ DDS / DMD Male / Female

ADA Number _____ Social Security Number _____

Colorado License Number and Year Issued _____ Date of Birth _____

Licenses Held In Other States And License Number(s) _____

Currently an ADA member elsewhere? In which state? _____ Dues paid for the 20____ year?

Applying as: New member _____ Associate member _____ Student _____ Transfer _____ Former member _____

If a former member, list the year(s) you were a member _____

Send mail to: Office _____ Home _____ (mail will be sent to office unless specified)

Practice Name _____

Office Address _____

City _____ State _____ Zip Code _____

Telephone _____ E-mail _____ Website _____

Fax Number to Use _____ I give the Metro Denver Dental Society (MDDS) permission to fax unsolicited advertisements regarding the commercial availability or quality of any property and goods or services including member benefits, services, products, events, continuing education, and MDDS endorsed products and services of third party providers.

Signature Required for Permission _____

Home Address _____

City _____ State _____ Zip Code _____

Telephone _____ E-mail _____

Dental School _____ Graduation date _____

Advanced Education Program _____ (School / Hospital)

City / State _____ Graduation date _____ (Please attach certificate)

Board Certified _____ Board Eligible _____ Year _____

Program Area:** Endo _____ Pediatric _____ Dental Public Health _____ Prostho _____ Ortho _____ Perio _____ Oral & Maxio _____

Radiology _____ Oral Path _____ Oral & Maxio Surg _____ General Practice _____ Other _____

Practice limited to this specialty? Yes / No

Type of practice: Solo _____ Group _____ Associate _____ Partner _____ Federal _____ Clinic _____ Employee _____ Other _____

Are / Were you a member of the American Student Dental Association? If so, please list years of membership _____

Payment method: Visa / Mastercard / Discover / Novus / Check # _____

Card number _____ Exp date _____

Name as it appears on the credit card _____

This bill is received at my _____ home _____ office Signature _____

I hereby certify that the information contained herein is true and correct and if subsequently proved incorrect shall be grounds for disapproval and / or removal. I certify that I will abide by the Principles of Ethics and Code of Professional Conduct and the Constitution and Bylaws of the ADA, CDA and MDDS, and that failure to abide by such can result in disciplinary action.

Signature of Applicant _____ Date _____