



MAIL THIS TRIPARTITE MEMBERSHIP APPLICATION TO:
TDA Member Services, 1946 S. IH-35 Ste 400, Austin, TX 78704
OR Fax to: 512-443-3031

LOCAL SOCIETY: _____

Name _____ Male Female
ADA Number _____ Social Security Number _____
Office Address _____ Telephone _____
City _____ State _____ Zip _____ Office Fax _____
Home Address _____ Telephone _____
City _____ State _____ Zip _____ Email _____
Primary Address: Home Office (Office address is used for component society assignment - Primary address is used for mailing purposes)

Applying as: New member Former member Graduate Student Transfer

ADA member: Yes No If yes, what state _____

Date of Birth _____ Spouse's Full Name _____
Dental School _____ Degree _____ Year of Graduation _____
Advanced Education Degree _____ Year of Graduation _____
Texas License Number _____ Year Issued _____
Other State License 1. _____ License # _____
2. _____ License # _____

Currently in a grad program? Yes No School _____ Program _____ Grad Year _____

Specialty Type _____ Board Certified _____ Board Eligible _____ Year _____
Endodontics Pathology Pediatric Dentistry Periodontics Public Health Oral & Maxillofacial
Oral & Maxillofacial Radiology Oral & Maxillofacial Surgery Orthodontics & Dentofacial

Practice Limited to _____
Type of Practice: Solo Group Associate Partner Employee Federal Other

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 authorize the Component Dental society membership chairman to seek any information concerning my candidacy for membership in the American Dental Association, the Texas Dental Association and the Component Dental Society and authorize the release of any such information for use in connection with this application to those people who are involved in the membership process.

I certify that I have received a copy of the Constitution and Bylaws, Principles and Ethics and the Code of Professional Conduct of the American Dental Association, Texas Dental Association, and Component Society and agree to abide by the tenets of these documents. I understand that failure to abide by such can result in disciplinary action. I am aware that if my application is not approved, or in the future my membership is rescinded, I can appeal the action.

Date _____ Signature of Applicant _____

For Component Dental Society Use Only

Date received: _____ Amount received with application: \$ _____ Action of the Component Dental Society: _____
Signed Component Judicial Committee Chairman _____
Signed by: _____ Date: _____

ALLOCATIONS FROM DUES FOR PUBLICATIONS ARE AS FOLLOWS: ADA JADA/\$25 & ADA NEWS/\$8, TDA TDJ/\$12, GHDS Journal/\$10.

For State Office Use Only: Date Received: _____ Total \$ _____ ADA _____ TDA _____ Local _____

Date Posted: _____ Staff: _____ Payment Method: _____