Membership Application

For membership in the American Dental Association and your state/local/district dental society (where applicable)

ADA American Dental Association®
America's leading advocate for oral health

1201 K Street
Sacramento, CA 95814
T 800.232.7645 cda.org

Department of Membership Operations
211 East Chicago Avenue, Chicago, Illinois 60611
T 312.440.2607 800.621.8099 ADA.org

Thank you for your interest in becoming a member.

The American Dental Association and your state and local/district (if applicable) 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/district, state and national. Your application will be processed and considered by your state or local/district 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/district society may request additional information. For complete information regarding the *Bylaws* and the *Principles of Ethics and Code of Professional Conduct* of the ADA which govern the professional conduct of members, please visit ADA.org/ethicsconduct. A list of state dental societies can be found at ADA.org/societydirectories.

Please complete all sections of this application. Print or type all information.
You may also be able to apply online. Please check your state dental society website for instructions.

Personal Information

Name (First) (Last) (Middle)				☐ Male ☐ Female
ADA ID Number (optional)	Date of Birth (MM/DD/YYYY)		Website Address	
Primary Office Address				Suite
City	State	Zip	Office Phone (include area code)	
Office Email			Fax (include area code)	
Home Address			Mobile Phone (include area code)	
City	State	Zip	Please indicate if you prefer to have mail sent to: ☐ Home ☐ Office	Please indicate if you prefer to have email sent to: ☐ Home ☐ Office
Home Email				
Spouse's Name (optional) (First) (Last) (Middle) (Alias/Previous/Maiden) Is spouse a dentist? ☐ Yes ☐ No				
If an ADA member encouraged you to join, please indicate:	Name			State

Race
☐ American Indian ☐ Asian ☐ Black ☐ Hispanic ☐ White ☐ Native Hawaiian or Pacific Islander ☐ Other ☐ Choose Not to Report

Biographical

Dental School	Country	Graduation Date (MM/DD/YYYY)
Advanced Education Program (if applicable)	Completion Date (MM/DD/YYYY)	Certificate/ Degree

Do you have a degree in an ADA recognized specialty? ☐ Yes ☐ No

If yes, which specialty?

☐ Anesthesiology ☐ Endodontics ☐ Oral & Maxillofacial Pathology ☐ Oral & Maxillofacial Radiology ☐ Oral & Maxillofacial Surgery
☐ Oral Medicine ☐ Orofacial Pain ☐ Orthodontics & Dentofacial Orthopedics ☐ Pediatric Dentistry ☐ Periodontics
☐ Prosthodontics ☐ Public Health

Please indicate if practicing in, or looking for:
☐ Solo ☐ Group ☐ Partnership ☐ Associateship ☐ Clinic ☐ Faculty ☐ Federal Dental Service
☐ Other:

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 ☐ License pending	If licensed, please list license number(s), date, year and state(s). Please indicate specialty license information if applicable.		

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Personal Background

Have you ever been denied a dental license? ☐ Yes ☐ No	If yes, in which state:	If yes, why?
Have you ever had your license suspended or revoked? ☐ Yes ☐ No	If yes, in which state:	If yes, why?
Have you ever been censored, suspended or expelled by a dentally related organization (i.e. dental society)? ☐ Yes ☐ No	If yes, in which state:	If yes, why?
Have you ever been convicted of a felony or criminal offense, including driving under the influence of alcohol or drugs, but excluding minor traffic violations and parking tickets? (A conviction record will not automatically bar you from membership. Each application will be individually considered on its merits.) ☐ Yes ☐ No	If yes, please describe (include dates, offenses and penalties):	

Please indicate how well each of the following 2 statements describes you:
(0 = Does not describe me at all → 10 = Describes me completely)

1. Helping people is the #1 reason I became a dentist Select One
2. Every day I seek excellence in the diagnosis and treatment of complex problems Select One

How proud were you at each of the following moments in your dental career?
(0 = Not at all proud/Not applicable → 10 = Extremely proud)

1. Graduating from dental school Select One
2. When a patient showed extreme gratitude after a procedure Select One
3. Helping a specific patient that was in need Select One
4. Successfully treating an extremely complex case for the first time Select One

Now, we would like to learn more about your work and personal beliefs. After you read each statement, please indicate how well each statement describes you.
(0 = Never or definitely no → 10 = Always or definitely yes)

1. If a coworker gets a prize, I would feel proud Select One
2. The well-being of my coworkers is important to me Select One
3. To me, pleasure is spending time with others Select One
4. I feel good when I cooperate with others Select One

Applicant Signature

I hereby apply for a tripartite membership in the American Dental Association and resolve to abide by the *Bylaws* and *Principals of Ethics and Code of Professional Conduct* if accepted into membership. If I have paid by credit card below*, my signature authorizes payment. Review the bylaws and code at ADA.org/ethicsconduct.

Signature	Date (MM/DD/YYYY)

**Your society will contact you if payment is required. Do not send payment now.*

To Be Completed By Society:

Constituent Society	Date Received (MM/DD/YYYY)		Approval Name	
	Date Approved or Disapproved (MM/DD/YYYY)		Approval Signature	
Component Society	Date Received (MM/DD/YYYY)		Approval Name	
	Date Approved or Disapproved (MM/DD/YYYY)		Approval Signature	
Dues Section	ADA	$	Method of Payment	
	Constituent	$	☐ Visa ☐ MasterCard ☐ American Express	
	Misc.	$	Credit Card Number	
	Misc.	$	Expiration Date (MM/YY)	Security Code
	Component	$	Name on Credit Card	
	Total Dues Owed	$		

Please submit your completed 2-page application to your state or local dental society. A listing of state dental societies is available on our website at ADA.org or you may contact the ADA Department of Membership Operations at 312.440.2607 for more information. Membership in the ADA is based on the calendar year from January to December. ADA dues allocation to ***JADA***, $25.00, to ***ADA News***, $8.00, and is not deductible from the dues amount.

United States Taxpayers Please Note: The tax law prohibits taxpayers from deducting the expenses that they incur by engaging in lobbying, as defined in the law. Accordingly, only that portion of an associations' member's dues not attributable to lobbying activities remains deductible as an ordinary and necessary business expense. The law requires associations to provide their members with a reasonable estimate of the non-deductible percent of their dues attributable to lobbying activities. For 2021, 6.8% of a member's ADA dues are allocated to lobbying activities. Dues payments and contributions are not deductible as charitable contributions for federal income tax purposes.