

**2017 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 _____
Last First Middle

Degree: ___ DMD
___ 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

Signature of Applicant

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