TRIPARTITE MEMBERSHIP APPLICATION

For membership in the American Dental Association, the New Hampshire Dental Society and your local Component Dental Society

Thank you for your interest in becoming a member of organized dentistry. The American Dental Association and your state and local 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, state and national. Your application will be processed and considered by your state or local 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 society may request additional information and will provide you with complete information regarding membership dues as well as the Bylaws and the Principles of Ethics and Code of Professional Conduct of the ADA and your state and local dental societies, which govern the professional conduct of members.

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

Personal

Name ____ ***Degree*** ❑ DMD ❑ DDS ❑ Other

First **Middle** **Last**

Office Address

Street ____ ***ADA #*** ________________________________

City ____

State/Zip/County____ ***Date of birth***___________________________

Office Phone ______________________ Fax_______________________________ ____ **❑M ❑F**

Home Address

Street____

City ____

State/Zip/County____

Home Phone ____

Spouse Name_____________ ____ **Is spouse a dentist?** ❑ Yes ❑No

Preferred Email________________________________ *Website*____________________________

Preferred method for contact ____

Please indicate preference for mail delivery ❑ Office ❑ Home

Biographical

Dental school ____ Graduation Date ____________________

Advanced Education Program ____

Completion Date_____________________________________ Certificate/Degree_____________

Program Areas

❑Endodontics ❑Pediatric Dentistry ❑Periodontics ❑Public Health
❑Prosthodontics ❑Orthodontics ❑Oral Pathology ❑Oral Radiology
❑Oral Surgery ❑General Practice ❑Other ______________________________

Is your practice limited to the above specialty? ❑ Yes ❑ No

❑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 _____________________________________Address ____

- Over -

License

Please indicate if licensed: ❑Presently ❑ License pending____

License number(s), date, year, states. Please include specialty license information if applicable.

Membership

Are/were you a member of the American Student Dental Association? ❑ Yes ❑ No If yes, ____________to _____________
Year *Year*

Please indicate your membership status in the American Dental Association:

❑ Current member with dues paid for the membership year.

State Society______________________________________

❑ Was previously an ADA member and member of____________________________________ Year_______
State Society

Professional Organizations, Activities and Additional Education

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Other information about you that may be of interest to NHDS Members

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Applicant Signature

I hereby apply for membership in the American Dental Society, the New Hampshire Dental Society and the local component society and resolve to abide by the Bylaws and the Principles and Code of Professional Conduct if accepted into membership.

Signature____***Date***___________________________________

Please return application to ***New Hampshire Dental Society***

- *Mail:* *23 So State Street*
  Concord, NH 0330l
- *Fax:* *603-226-4880*
- *Email:* *nhds@nhds.org*