Retired Affidavit

IDA Iowa Dental Association
666 Grand Avenue, Suite 901, Des Moines, Iowa 50309
iowadental.org

ADA American Dental Association®
America's leading advocate for oral health
Department of Membership Information
211 East Chicago Avenue, Chicago, Illinois 60611
ADA.org

Please print or type all information.

To Be Completed by the Member Dentist

Retired Membership is available to an active member in good standing who has been an active member and is now a retired member of a constituent society, if such exists, and is no longer earning an income from the performance of service as a member of the faculty of a dental school, as a dental administrator or consultant, or as a practitioner of any activity for which a license to practice dentistry or dental hygiene is required by the state.

Retired Life Membership is available to a member who meets the above requirements for retired membership and who meets the requirements for life membership. Life membership is available to a member who has been a member for 30 consecutive years or 40 total years, and has attained age 65 and is a member in good standing. Life membership is effective the calendar year following the year in which these requirements are fulfilled.

I, Dr. _____, _____,
(ADA ID Number)

desiring to be elected to: ☐ Retired Membership ☐ Retired Life Membership in the American Dental Association state

that I am currently a member in good standing of the _____
(Constituent Dental Society or Branch of Service)

and that I was born _____ (MM/DD/YYYY) and have retired from the practice of dentistry effective _____ (MM/DD/YYYY), and

I am no longer earning income from the performance of service as a member of the faculty of a dental school, as a dental administrator or consultant, or as a practitioner of any activity for which a license to practice dentistry or dental hygiene is required.

Signature: _____

Current Mailing Address			Phone (include area code)
City	State	Zip	Is this your: ☐ Home ☐ Office
Permanent Email Address			
New mailing address (optional)			Phone (include area code)
City	State	Zip	Starting date for new address (MM/DD/YYYY)

Please send your completed form to your local dental society. They will forward it to your state society, who will return it to the ADA. Contact information for state and local societies is available at ADA.org/societydirectories.

To Be Completed by the Constituent and Component Societies

The _____ (Constituent Dental Society), and the _____ (Component Dental Society),

certify that the above applicant is a member in good standing for _____ (Year paid) and is now a retired member of these societies.

Number of years' membership in Constituent Society:	
Signature of Constituent Executive Director:	Signature of Component Executive Director:

ADA Use Only

Member Year	Current Status	☐ Approved ☐ Not Approved	☐ Returned for more information ☐ Letter Sent
History Check		☐ Practice ☐ Address ☐ Dues Detail ☐ Biographical ☐ Category	