

MEMBERSHIP APPLICATION
OREGON DENTAL ASSOCIATION/AMERICAN DENTAL ASSOCIATION
DENTAL SOCIETY

INSTRUCTIONS TO APPLICANT: *Each question must be answered fully. Use separate sheet wherever necessary.*

Name _____ DDS ___ DMD ___ Other ___
First Middle Last

Date of Birth _____ Social Security number _____ Sex M ___ F ___

Spouse Name _____ Is Spouse a dentist? Yes ___ No ___

Primary Office Address

Address _____ Telephone _____

City _____ State _____ Zip _____ Fax _____

Office Email _____ Professional Corporation? Yes ___ No ___

Directory Listing Address (this address listing will be printed in the ODA Directory & Resource Guide)

Address _____ Telephone _____

City _____ State _____ Zip _____ Fax _____

Home Address

Address _____ Telephone _____

City _____ State _____ Zip _____ Fax _____

Preferred Mailing Address: Office _____ Home _____

Dental School _____ Graduation Date ____/____/____
mm dd yyyy

Advanced Education Program _____ Completion Date ____/____/____
mm dd yyyy

Is your practice limited to a specialty? Yes ___ No ___ Specialty _____

American Board Certified? Yes ___ No ___ Oregon License _____ Year _____

Are/Were you a member of American Student Dental Association (ASDA) Yes ___ No ___ If yes, from ____ to ____
yyyy yyyy

Are you presently a member of the ADA? Yes ___ No ___ ADA Membership Number _____

I am ___/was ___ a member of the following dental societies: *(Give State and local societies or Federal Dental Service)*

Has your license to practice dentistry ever been revoked, suspended, or limited for disciplinary reasons? Yes ___ No ___
(if yes, state facts fully on separate sheet)

If you have ever been known by another name, please state: _____

I hereby agree to abide by the By-Laws, Principles of Ethics and Code of Professional Conduct of the _____
Dental Society, the Oregon Dental Association, and the American Dental Association.

I recognize that membership in the _____ Dental Society, Oregon Dental Association, and the American
Dental Association is a privilege. I further recognize these organizations are required to investigate the qualifications of applicants and
maintain standards of conduct for members.

In order to perform adequately their investigatory and disciplinary functions, these organizations must be free to perform these functions
without a fear of litigation by rejected applicants or disciplined members. Therefore, in exchange for their consideration of this
application, I hereby release the organizations, their members, and anyone acting on their behalf from liability for damages for any acts
performed in connection with the application or disciplinary process. This release includes, but is not limited to, claims for defamation,
invasion of privacy, and intentional interference with business relationship, and applies regardless of the intent with which the act is
performed. I hereby consent to any investigation of the facts disclosed in my application, to any disciplinary investigation, and to any
statements made in connection with the application or disciplinary process, by whomever made and whether defamatory or not.

Signature _____ Date _____

FOR COMPONENT USE ONLY

Applicant Name _____

Dental Society _____

Date Application Received: _____

Date Referred to committee on membership admissions _____

_____ **APPROVED** _____ **DISAPPROVED**

Signed _____ Date _____
(Chairman of Membership Committee)

VOTED ON BY _____
(Name of Component Society)

_____ **ELECTED** _____ **REJECTED**

AT A MEETING HELD ON _____
(Date)

SIGNED BY _____
(Secretary of Component Society)

PLEASE FORWARD THIS COMPLETED FORM TO THE ODA CENTRAL OFFICE, PO Box 3710, WILSONVILLE, OR 97070, IMMEDIATELY AFTER ELECTION TO MEMBERSHIP.