MEMBERSHIP APPLICATION

OREGON DENTAL ASSOCIATION/AMERICAN DENTAL ASSOCIATION

_____ DENTAL SOCIETY

INSTRUCTIONS TO APPLICANT: *Please print clearly. Each question must be answered fully. Fax completed application to 503-218-2009*

Name _____ DDS___DMD___Other_____
First Middle Last

Date of Birth_____ Preferred Name/Nickname_____ Sex M___F____

Spouse Name_____ Is Spouse a dentist? Yes___ No____

Primary Office Address _____ _____
Address Office **Telephone**

_____ _____
City State Zip **Office Fax**

Office Email_____ Website_____

Practice Model: In order to better serve you, we'd like to know your current primary practice model. If applicable, please name the organization with which your practice is affiliated. Group practice definitions are given on the back side of this page.

☐ Faculty ☐ Solo Private Practice ☐ Dentist Owned and Operated Group Practice

☐ Dental Management Organization Affiliated Group Practice (DM: _____)

☐ Insurer-Provider Group Practice (Insurer: _____)

☐ Not-for-Profit Group Practice (Organization: _____)

☐ Government Agency Group Practice (Agency: _____)

☐ Hybrid Group Practice (Comments: _____)

Home Address _____ _____
Address Home Telephone

_____ _____
City State Zip Home Fax

Home Email_____ _____
Cell

Directory Listing: Address/Phone - Office ___ Home ___ Email - Office ___ Home ___ Do not list ___ Website - Yes ___ No ___
(The above will be listed on the public portion of the ODA website under "Find a Dentist"; retired dentists are listed under the member portion only of the ODA website)

Preferred Mailing Address: Office____ Home____ Preferred Email Address: Office____ Home____

Preferred Phone Contact: Office____ Home____ Cell____

Prefer to receive ODA communications (check only one): Email_____ Mail_____

Prefer to receive Membership Matters newsletter via (check only one): Email_____ Mail_____

Education/Specialty:

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**_____

If an ODA Member encouraged you to join, please indicate: Name_____

ADA Group Practice Definitions

Throughout this classification, 'group' refers to two or more dentists that are somehow affiliated with each other.

Dentist Owned and Operated Group Practice: More than one dentist in a single practice that may be located at a single or multiple sites. Completely owned and operated by dentists, usually organized as a partnership or professional corporation.

Dental Management Organization (DMO) Affiliated Group Practice: A group practice that has contracted with a DMO to conduct all of the business activities of the practice that do not involve the statutory practice of dentistry, sometimes including the ownership of the physical assets of the practice.

Insurer-Provider Group Practice: A group practice that is part of an organization that both insures the health care of an enrolled population and provides their health care services.

Not-for-Profit Group Practice: A group practice that is operated by a charitable, educational, or quasi-governmental organization that often focuses on providing treatment for disadvantaged populations or training healthcare professionals.

Government Agency Group Practice: A group practice that is part of a government agency. It is organized and managed completely by the agency. All dentists are government agency employees or contractors and operate according to agency policies.

Hybrid Group Practice: A group practice that does not clearly fit into any of the above categories and can exhibit some characteristics of several of them.