Tripartite Membership Application

ADA#(if Known): _____ Date: _____ Birth Month/Day/Year_____

Name:_____ _____ _____ _____ Gender: F ☐ M ☐
Last First Middle DDS/DMD

Maiden Name: _____

Home Street Address:_____

City _____ State: _____ Zip:_____

Home Phone: (_____) _____

Cell: (_____) _____ Preferred Phone: Home ☐ Cell ☐ Office ☐

Email: _____ Mail to: Office ☐ Home ☐

Spouse Name: _____ Is your spouse a dentist? ☐ Yes ☐ No

Ethnic background (optional)
Caucasian ☐ Asian ☐
Native American ☐
African American ☐
Hispanic ☐

PRIMARY OFFICE

Street Address: _____

City:_____ State _____ Zip:_____

Phone: (_____)_____ Fax: (_____)_____

Practice website: _____

EDUCATION/SPECIALTY

Dental School: _____ Year of Graduation: _____

PostGrad/Residency: _____Certificate/Degree_____ Year of Graduation: _____

Does your specialty designation meet the guidelines or requirements for specialties approved by the Commission on Dental Accreditation and the Council on Dental Education of the ADA? If a box is not checked, you will be listed as a general practitioner. ***You must submit a copy of your specialty degree/diploma to be listed as a specialist***

If so, check one: Endo ☐ Pediatric ☐ Perio ☐ Public Health ☐ Prostho ☐ Ortho ☐ Oral Path ☐

Oral Surg ☐ Other ☐ Is your practice limited to the above specialty? Yes ☐ No ☐

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PRACTICE/LICENSURE

Is your practice incorporated? Yes ☐ No ☐ License Number: _____
License #(s)/date/state

MEMBERSHIP INFORMATION

Please indicate your membership status in the American Dental Association:

☐ Never been a member

☐ Current member in _____ with dues paid for the 20 _____ membership year

☐ Was previously a member in _____ and _____
(State association) (local society)

Have you ever had any disciplinary charges made, or any disciplinary actions taken, against you by any State dental association or State agency? Yes ☐ No ☐

Cardholders Electronic Signature_____

By entering my name, I hereby certify that the information contained herein is true and correct. I agree to abide by the Articles of Incorporation, Bylaws and Code of Ethics of the American Dental Association and the Washington State Dental Association.

PLEASE SCAN/EMAIL OR FAX YOUR COMPLETED APPLICATION TO LAURA ROHLMAN AT 206.973.5208 OR LAURA@WSDA.ORG OR HIT THE SUBMIT BUTTON AT THE TOP RIGHT HAND CORNER OF THE APPLICATION AND FOLLOW THE INSTRUCTIONS PROVIDED.

LOCAL COMPONENT SOCIETY USE ONLY

Society: _____ **Application status: Approved** ☐ **Denied** ☐

Authorizing Person: _____ Date:_____