

# Tripartite Membership Application

ADA#(if Known): \_\_\_\_\_ Date: \_\_\_\_\_ Birth Month/Day/Year \_\_\_\_\_

Name: \_\_\_\_\_  
Last First Middle DDS/DMD

Gender: F  M

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

## 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: \_\_\_\_\_