



29 Trailwood Drive, Fountain Inn, SC 29644
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APPLICATION FOR MEMBERSHIP

I hereby apply for membership in the Delaware State Dental Society and the American Dental Association.

I am applying for (circle one): ACTIVE, LIFE, STUDENT, HONORARY, AFFILIATE, ASSOCIATE, OR RETIRED

Name (last, first, middle initial) _____

Main Office Address: Street _____

Main Office Address: City _____ State _____ Zip Code _____

Phone Number _____ Fax Number _____

Email Address _____

Home Address: Street _____

Home Address: City _____ State _____ Zip Code _____

Home Phone Number _____

Date of Birth _____ Sex _____ Social Security No. _____

Marital Status _____ Spouse's Full Name _____

Dental School _____ Degree _____ Year _____

DE License Number _____ Date of DE License _____

Also Licensed to Practice in (list states) _____

Specialty _____ Year of Eligibility _____ Year Certified _____

Type of Practice (General or Specialty) _____ ADA Number _____

DE Anesthesia Permit No. _____ DE DEA Number _____

Were you a member of the American Student Dental Association at the time of your graduation? YES_____ NO_____

Internship_____ Dates_____

Residency_____ Dates_____

Full Time Graduate Study_____ Dates_____

Military Service_____ Dates_____

List any current hospital or school affiliations or positions_____

Do you have any dental lawsuits pending? If yes, please explain_____

Have you ever been a member of the ADA? YES_____ NO_____ If yes, give dates: From_____ To_____

Previous State Society_____ Previous Component Society_____

If elected into membership, I promise to abide by the Constitution and Bylaws and Code of Ethics of the American Dental Association and the Delaware State Dental Society.

Signature of Applicant_____ Date_____