



TRIPARTITE MEMBERSHIP APPLICATION

For membership in the American Dental Association,
Louisiana Dental Association and local dental societies.

Date ADA Membership Number Social Security Number Date of Birth

Name _____
(Last) (First) (Middle)

Louisiana State Board of Dentistry License # _____ Date originally issued: _____

Indicate if you prefer to have mail sent to: ____ Office ____ Home

OFFICE ADDRESS

Street Address _____

City/State/Zip _____

Phone (____) _____ Fax # (____) _____ E-Mail: _____

HOME ADDRESS

Street Address _____

City/State/Zip _____

Phone (____) _____ Fax Number (____) _____

Spouse Name _____ Is spouse a dentist? ____ Yes ____ No

Dental School _____ Graduation Date _____

Advanced Education Program _____ Completion Date _____
(School/Hospital)

Program Area(s): ____ Endo ____ Pediatric ____ Perio ____ Public Health ____ Prosthodontics ____ Orthodontics
____ Oral Path ____ Oral Surgery ____ General Practice ____ Other

Is your practice limited to the above specialty? ____ Yes ____ No

Indicate if: ____ Currently practicing
____ Looking for a dental practice opportunity in _____
(City / State)

Indicate if practicing in, or looking for: ____ Solo ____ Group ____ Partnership ____ Associateship
____ Clinic ____ Faculty ____ Federal Dental Service ____ Other

Indicate your membership status in the American Dental Association:

Current member in _____ with dues paid for the 20____ membership year
(State Society)

Was previously a member in _____ and _____ from _____ to _____
(State Society) (Local Society) year year

I hereby make application for membership in the _____ (local component) Dental Association, Louisiana Dental Association, and the American Dental Association. If accepted, I will abide by the Bylaws of these associations.

Signature of Applicant (Date)

Signature of Sponsor must be signed by an active or life member of the local component association to which application is being made.

Signature of Sponsor (Telephone Number)

For Association Entry Only

Application received by Membership Department _____ Amount received with application \$ _____
(Date)

COMPONENT SECRETARY:

Date Received: _____

Recommendation: _____

BOARD OF GOVERNORS:

Date Received: _____

Recommendation: _____

REFERRED TO COMPONENT ASSOCIATION FOR BALLOTING:

At a meeting held on _____
(Date of Meeting)

_____ Elected _____ Rejected

Signature (Component Secretary)

Component Association

Thank you for your interest in becoming a member of organized dentistry. The American Dental Association and your state and local dental societies have a tripartite membership structure. Therefore, final approval of your application provides you with membership at all three levels of your professional associations: local, state and national. Your application will be processed and considered by your state or local dental society, which will provide you with additional information regarding their specific application procedures. Please apply to the society where you conduct or will conduct the major portion of your practice. Your state or local society may request additional information and will provide you with complete information regarding membership dues as well as the *Bylaws* and the *Principles of Ethics and Code of Professional Conduct* of the ADA and your local dental societies, which govern the professional conduct of members.

PLEASE SUBMIT YOUR COMPLETED APPLICATION IN THE ENCLOSED ENVELOPE.