



LOUISIANA DENTAL ASSOCIATION

Student Membership Application

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(225) 926-1986 • (800) 388-6642
FAX: (225) 926-1886 • (800) 343-3842
www.ladental.org

Date _____

ADA ID Number _____

Date of Birth ____/____/____

Name _____
First Middle Last

Male Female

Mailing Address _____

City/State/Zip _____ Phone (____) _____

FAX (____) _____ E-mail Address _____

School _____

Address _____ City/State/Zip _____

Year in School _____ Expected Date of Graduation _____

Are you planning on attending an advanced education program? If so, where (what school)? _____

Specialty: (Circle all those that apply.) Endo. Ped. Dent. Perio. Public Health Prostho.

Ortho. Oral Path. Oral Surg. Oral & Max. Rad.

In what city and state are you planning to practice? _____

Spouse's Name _____

Is your spouse attending or planning to attend dental school? (Circle one) YES NO

I hereby apply for student membership in the Louisiana Dental Association, and resolve to abide by the Bylaws and the Code of Ethics and Professional Conduct if accepted into membership.

Signed _____ Date _____

Please return your completed form to the LDA at the above address or fax number.