

FLORIDA DENTAL ASSOCIATION

1111 E. Tennessee St. • Tallahassee, FL 32308-6914
Phone: (800) 877-9922, Ext. 136 • E-mail: membership@floridadental.org • Web site: www.floridadental.org

Membership Application

Thank you for your interest in membership. Approval of your application provides you with membership in all three levels of your professional association: national, state and district. Applications are processed by the FDA and your district dental association.

PLEASE TYPE OR PRINT

Name

Degree: DMD DDS
Other: _____

Last First Middle

Primary Office Address

Social Security Number: _____

Street: _____

City: _____ State: _____ Zip: _____ County: _____

ADA Number: _____

Phone:(____) _____ Fax:(____) _____ Cellular:(____) _____

E-Mail: _____ Web site: _____

(if known)

Date of Birth: _____

Home Address

Street: _____

City: _____ State: _____ ZIP : _____ County: _____

Please indicate primary mailing address: Office Home

Phone: (____) _____ E-Mail _____

Spouse name: _____

Is spouse a dentist?
 Yes No

Dental School: _____ Graduation date: _____ / _____ / _____

Postgraduate program: _____ / _____

Beginning date: _____ Completion date: _____ Certificate/Degree: _____

Florida license number: _____ Year: _____ License pending _____
City State Country

Florida permit number: _____ Year: _____ Permit pending _____

Licenses held:

1. _____ License number: _____

2. _____ License number: _____

Specialty: _____ Board certified: yes no Date: _____ / _____ / _____

Current practice:

Location: _____ Dates: _____ - _____

Solo Practice Employee Partnership Group Practice Clinic Public Health

Institution _____ Faculty Hospital Non-Florida license; not practicing; administrative
(Dentists must report address changes to the Board of Dentistry within 10 working days)

If practicing in other than a solo practice, please indicate the group or practitioners name and location:

If not practicing now, please indicate where you are looking to practice:

Are/were you a member of the American Student Dental Association? Yes No If yes, from _____ to _____

Please indicate your membership status in the American Dental Association:

Current member State Society/Association _____

Previous member State Society/Association _____ from _____ to _____

Have you ever been disciplined by any ethics committee or any duly constituted equivalent body? yes no If yes, please give details and findings. _____

Have you ever been disciplined by any state licensing agency or department? yes no If yes, please give details and findings. _____

Have you ever been convicted or found guilty of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony or first-degree misdemeanor? yes no If yes, please give details and findings. _____

Have you ever had a judgment of malpractice entered against you? yes no If yes, please include details and findings. _____

I hereby certify that the information contained herein is true and correct and if subsequently proved incorrect shall be grounds for disapproval and/or removal. I certify that I have read and will abide by the Articles of Incorporation, Bylaws and Code of Ethics of the American Dental Association, Florida Dental Association and Component Dental Association. I authorize the Component Dental Association membership chairperson to seek any information concerning the above questions for use in considering my candidacy for membership in the aforementioned associations and authorize the release of any such information for use in connection with this application to those people who are involved in the membership process.

Applicant's name: _____

Signature: _____ Date: _____

This information is voluntary, but it will assist the FDA in developing diversity outreach programs:

Gender: Male Female Ethnicity: African-American Asian Caucasian Hispanic Native American Other

DISTRICT DENTAL ASSOCIATIONS

Atlantic Coast District Dental Association

Broward (North)
Indian River
Martin
Okeechobee
Palm Beach
St. Lucie

Central Florida District Dental Association

Alachua
Brevard
Flagler
Gilchrist
Lake
Levy
Marion
Orange
Osceola
Seminole
Sumter
Volusia

Northeast District Dental Association

Baker
Bradford
Clay
Columbia
Dixie
Duval
Hamilton
Lafayette
Madison
Nassau
Putnam
St. Johns
Suwannee
Taylor
Union

Northwest District Dental Association

Bay
Calhoun
Escambia
Franklin
Gadsden
Gulf
Holmes
Jackson
Jefferson
Leon
Liberty
Okaloosa
Santa Rosa
Wakulla
Walton
Washington

South Florida District Dental Association

Broward (South)
Dade
Monroe

West Coast District Dental Association

Charlotte
Citrus
Collier
De Soto
Glades
Hardee
Hendry
Hernando
Highlands
Hillsborough
Lee
Manatee
Pasco
Pinellas
Polk
Sarasota

For FDA Office Use Only

Date application received: _____ Amount \$ _____

For Component Dental Association office use only

Date application received : _____

Date referred to Component Membership committee: _____

Action of Component Dental Association: yes no

Deferred until: _____ / _____ / _____

Signature of authorized component officer: _____ Date: _____

**Please use the enclosed postage-paid envelope and mail this application to:
Membership Department • Florida Dental Association • 1111 E. Tennessee St. • Tallahassee, FL 32308-6914**