FLORIDA DENTAL ASSOCIATION

1111 E. Tennessee St. • Tallahassee, FL 32308-6914 • Phone: 800.877-9922/850.681.3629
Fax: 850.201.5013 • 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

_____
LAST FIRST MIDDLE

Degree: ❑ DMD ❑ DDS
Other: _____

Social Security number:

_____ ___ _____

ADA Number:

_____
(IF KNOWN)

Date of birth:

_____

Primary Office Address

Street: _____

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

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

E-mail: _____ Web site: _____

Home Address

Street: _____

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

Phone: (____) _____ E-mail: _____

Spouse name: _____

Please indicate primary mailing address: ❑ Office ❑ Home

Is spouse a dentist?
❑ Yes ❑ No

Dental school: _____ Graduation date: _____/_____/_____

Postgraduate program: _____/_____
CITY STATE COUNTRY

Beginning date: _____ Completion date: _____ Certificate/degree: _____

Florida license number: _____ Year: _____ License pending: _____

Florida permit number: _____ Year: _____ Permit pending: _____

Licenses held:

1. _____ License number: _____

2. _____ License number: _____

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

Current practice:

Location: _____ Dates: _____ – _____
(Dentists must report address changes to the Board of Dentistry within 10 working days)

❑ Solo practice ❑ Employee ❑ Partnership ❑ Group Practice ❑ Clinic ❑ Public health

❑ Institution: _____ ❑ Faculty ❑ Hospital ❑ Non-Florida license; not practicing; administrative

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

_____

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 _____

Referred for membership by: _____

FDA FORM: 07/2008

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. I authorize the Florida Dental Association, its affiliated entities and component/affiliate dental associations to contact me via the listed facsimile number and e-mail address.

Applicant's name: _____

Signature:_____ Date: _____

This information is voluntary, but it will help the FDA develop 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 $ _____

WEB

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 fax or mail this application to the FDA Membership Department:
1111 E. Tennessee St. • Tallahassee, FL 32308-6914 • Fax: 850.201.5013