AADA Membership Application

Please Print Clearly *(all information is required)*

Applicant ______________________________ DMD DDS Spouse/Partner ______________________________ DMD DDS

Other Family Member __________________________ Relation to Applicant ______________________________

Home Address ______________________________City, State __________________________ Zip____________

Cell Ph: ____________ E-Mail__________________________ SP/Partner E-Mail__________________________

I would like to JOIN or RENEW myself and/or my Spouse/Partner/Family as:

Member

Self ☐ $50 Spouse/Partner ☐ $50 Other Family Member ☐ $5

Spouse, Partner or Family Member of an ADA Member Dentist or an ADA Member Dentist.

New Dentist Member

Self ☐ $20 Spouse/Partner ☐ $20 Other Family Member ☐ $50

Spouse, Partner or Family Member of a New Dentist or a New Dentist. Dentist must be an ADA Member, 1-4 years out of school.

Student or Resident Member

Self ☐ $5 Spouse/Partner ☐ $5 Other Family Member ☐ $50

Spouse, Partner or Family Member of an ASDA/ADA Member or an ASDA/ADA Member.

Total $ ______________

Mail this form with check payable to *AADA* or email this form with credit card info below:

Alliance of the American Dental Association
P.O. Box 1982, Brandon, FL 33509
Ph: 813-540-2154, Fax: 813-315-7132 E: info@allianceada.org

I am interested in the following (*mark all that apply*)

- ☐ Dental Health Education and projects
- ☐ Legislative Advocacy: issues impacting dentistry
- ☐ Membership & Communication
- ☐ Serving in a leadership role
- ☐ Practice management information
- ☐ Well-being of the dental family
- ☐ Meeting other members and having fun

Name on Credit Card ____

Credit Card #____ Exp __________ CVV ______

Billing Address ______________________________City, State_______________ Zip __________

Signature______________________________________ Date __________________________