ARIZONA DENTAL ASSOCIATION
APPLICATION FOR MEMBERSHIP

3193 N Drinkwater Blvd, Scottsdale, AZ 85251
480.344.5777 | Fax: 480.344.1442 | www.azda.org | membership@azda.org

Arizona Dental Association

American Dental Association

Local Dental Society

Please complete all questions on this application and return with the following:

1. Recent head and shoulder photograph of yourself.
2. Membership Dues (if applicable)
3. Copy of specialty certificate required, if applicable

Please check your application for thoroughness before mailing to the AzDA Office. Completed applications will be considered at the next regularly scheduled Board Meeting. You will be notified of the results following the meeting. Thank you for applying for membership.

Please print

Name ____
Last First Middle

Phonetic Pronunciation *(to help us pronounce your name when we give referrals):* ____________________

ADA # ___ ___ ___ __ __ ___ ___ ___ ___ **SS #** ___ ___ ___ __ __ ___ ___ ___ ___

AZ Dental License # ____________ **DOB:** ____________ **Sex:** ❐ **M** ❐ **F**

ADDRESSES

Primary Office

Name of Practice: ______________________________

Street Address ______________________________

City ____________ State ______ Zip Code ______

Tel ( ) ____________ Fax ( ) ____________ Website: ____________

Alternate Office

Name of Practice: ______________________________

Street Address ______________________________

City ____________ State ______ Zip Code ______

Tel ( ) ____________ Fax ( ) ____________ Website: ____________

Are you the: ❐ **Owner** ❐ **Associate** ❐ **Independent Contractor** ❐ **Employee**

Home

Street Address ______________________________

City ____________ State ______ Zip Code ______

Tel ( ) ____________ Fax ( ) ____________

Preferred Mailing Address for all Association correspondence, *(e.g., publications, membership info, continuing education promotion, etc.)*

❐ **Primary Office** ❐ **Home**

E-mail Address: ______________________________

AzDA Membership Application (cont.)

Please indicate the type of practice you are limited to (please submit copy of specialty certificate):

❒ Endodontics ❒ Pediatric ❒ Periodontics ❒ Public Health ❒ Prosthodontics ❒ Oral Radiology

❒ Orthodontics ❒ Oral Pathology ❒ Oral Surgery ❒ General Practitioner ❒ Other ____________

EDUCATION

Dental School/Hospital: ____________________

Graduation Date: ____________________ Degree Earned: ____________

Internship: ____________________ From ________ To ________

Post Graduate Training ____________________ From ________ To ________

Other Training ____________________

MEMBERSHIP AGREEMENT

Please read carefully and sign

I HEREBY APPLY for membership in the American Dental Association, Arizona Dental Association and my local dental society and resolve to abide by the *Constitution and Bylaws*, *Principles of Ethics and Code of Professional Conduct* and the *Peer Review Program* of each organization, if elected for membership.

I CERTIFY THAT all statements made by me in this application are complete, true and honest. I understand and agree that if any statement is found to be false or omitted, this application may be rejected solely for that reason. I also understand and agree that in the event such false statement(s) or omission(s) does not become known to the Dental Society until after I have been elected, I understand that my membership may be terminated immediately on the basis of incomplete or false information. For the purposes of this paragraph, I understand that a material misstatement or omission shall mean, one which is “significant in relation to the questions asked to which the false statement or to which the omission was made.”

I FURTHER AGREE that I will recognize the authorized officers of my local dental society and said Associations as the proper and sole authorities to interpret all areas of professional conduct and interpretations.

UPON BECOMING A MEMBER of the local dental society, Arizona Dental Association and the American Dental Association, I hereby waive the right to hold this society, the Associations or any member thereof, responsible for any damage in case of disciplinary action involving me, after a hearing in accordance with the Bylaws of this society, the Arizona Dental Association and the American Dental Association.

I have read and understand the above membership agreement.

____________________ Signature of Applicant ____________ Date

I was referred/recruited to member by Dr. ____________________

If approved for membership, I would like to get involved in the following areas:

❒ Ethics/Peer Review ❒ Communications ❒ Dental Health ❒ Legislation

❒ Membership Socials ❒ Continuing Education ❒ New Dentist Activities ❒ Speaker’s Bureau

❒ Volunteer Opportunities ❒ Donated Dental Services ❒ Foundation Activities ❒ Fundraising/Program Dev

REFERRAL INFO

AzDA provides approximately 300 referrals each week to member dentists through telephone inquiries and the web site at azda.org. So the most up-to-date information can be passed along to referrals, please check each service your dental office provides.

❒ Bleaching/Whitening
❒ Cancer Patients *(Radiation & Chemo therapy)*
❒ Cosmetic Dentistry
❒ Dental Phobias
❒ Dentures
❒ Emergencies
❒ Evening Hours

❒ Financing, Tx
❒ Friday Hours
❒ Hospital Privileges
❒ Implants
❒ IV Sedation/Anesthesia
❒ Lasers
❒ Latex Allergies
❒ Nitrous Oxide

❒ Nursing Home Calls
❒ Oral Conscious Sedation
❒ Pediatric Dentistry
❒ Saturday Hours
❒ Senior Discounts
❒ Sign Language
❒ Special Needs
❒ TMD/TMJ

❒ Wheelchair Access
❒ General Anesthesia
❒ Foreign Language(s): ____________

AzDA

Please return your completed application to:
AzDA | 3193 N Drinkwater Blvd, Scottsdale, AZ 85251