Application for Membership

Please complete (print) application and return to CSDA

Connecticut State Dental Association
835 West Queen Street
Southington, CT 06489

860.378.1800 / phone
860.378.1807 / fax

CSDA.com

ADA # _____ CT LICENSE # _____

NAME _____ ❑ DMD ❑ DDS

PRIMARY PRACTICE NAME _____

PRIMARY PRACTICE ADDRESS _____

CITY / STATE / ZIP _____

( ) _____ ( ) _____

BUSINESS PHONE BUSINESS FAX

EMAIL ADDRESS _____

HOME ADDRESS _____

CITY / STATE / ZIP _____

( ) _____ ( ) _____

HOME PHONE MOBILE PHONE

❑ Male ❑ Female _____ _____

GENDER DATE OF BIRTH SOCIAL SECURITY #

❑ Single ❑ Married _____ ❑ Yes ❑ No

MARITAL STATUS SPOUSES' NAME IS SPOUSE A DENTIST?

DENTAL SCHOOL _____ YEAR OF GRADUATION _____

ADVANCED EDUCATION _____ YEAR OF GRADUATION _____

❑ Endo ❑ Pediatric ❑ Perio ❑ Public Health ❑ Prostho ❑ Orhto ❑ Oral Path ❑ Oral Surg ❑ General Pract

PROGRAM AREA(S)

LICENSED IN STATE(S) OF _____

❑ Yes ❑ No _____

HAVE YOU EVER BEEN A MEMBER OF THE ADA? IF YES, WHEN

IF ELECTED, YOU WOULD BE AN ACTIVE MEMBER OF THE (NAME COMPONENT SOCIETY) _____

ENDORSEMENT OF TWO (2) CURRENT MEMBERS OF THE LOCAL SOCIETY (NAME ONE) _____ (NAME TWO) _____

You will be billed for dues once your file is received from the ADA. Please call if you have questions regarding dues amount.

If elected to membership, I agree to comply with the Constitution, By-Laws and Principles of Ethics of the Component Society, Connecticut State Dental Association, and the American Dental Association. I further agree to surrender, upon demand of proper authority, all certificates of membership granted me by this Association.

SIGNATURE _____

For Component Society Secretary

❑ Elected
❑ Rejected

COMPONENT SOCIETY _____ NAME OF APPLICANT _____

BY ACTION OF _____ AT A MEETING HELD ON _____