Membership Application 2017

Alliance of the American Dental Association
the reason to smile

Please Print Clearly

Applicant's Name

First Name_____ Last Name_____

Spouse's First Name _____Spouse's Last Name_____

Applicant's Home Address_____

City, State _____ Zip _____

Cell Phone_____ Home Phone _____ Work Phone_____

E-Mail* _____

*Required. Used solely for AADA information and not sold to third parties.

I would like to ☐ JOIN or ☐ RENEW as

☐ Active (National) Member (spouse/partner an ADA member) $50.00

☐ Student Spouse Member (apouse/partner an ASDA member) $5.00

Since we are a tripartite organization, Component (local) and Constituent (state) dues may apply in your District. If this applies, you will be contacted.

Pay with: PayPal

OPTIONAL INFORMATION

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

- ☐ **dental health education projects in my community**
- ☐ **dental health education projects statewide**
- ☐ **helping other members with a project**
- ☐ **meeting other spouses and having fun**
- ☐ **learning more about Alliance benefits**
- ☐ **legislative issues impacting dentistry**
- ☐ **supporting the American Dental Political Action Committee (ADPAC)**
- ☐ **practice management information**
- ☐ **meeting people with similar concerns**
- ☐ **well being of the dental family**
- ☐ **right now, only as a supportive member, but keep me in the loop**
- ☐ **having a mentor/buddy**

Student Spouse DENTIST Information

Dental School _____ Graduation Year _____

If graduating this year and you know your forwarding address, please complete: Effective Date _____

Home Address _____

City, State_____ Zip _____