

**APPLICATION FOR MEMBERSHIP IN
LOCAL DISTRICT DENTAL SOCIETY, THE ALABAMA DENTAL ASSOCIATION
AND THE AMERICAN DENTAL ASSOCIATION**

Please complete all sections of this application and return it to ALDA, 836 Washington Avenue, Montgomery, AL 36104 or fax 334.262.6218. Print or type all information.

Date _____ **District** _____

Name _____
Last First Middle

Degree: ___ DMD ___ DDS _____ **Gender:** ___M ___F
Birth Month/Date/Year

Office Address

Street _____ City _____

State/Zip _____ E-Mail _____

Phone (____) _____ Fax (____) _____

Home Address

Street _____ City _____

State/Zip _____ Phone(____) _____

Spouse Name _____ Is spouse a dentist? ___ Yes ___ No

Please indicate if you prefer to have mail sent to: ___ Office ___ Home

Dental School _____ **Graduation Date** _____

Advanced Education Program _____
School/Hospital City/State

Completion Date _____ **Certificate/Degree** _____

Program Area(s): Endodontics ___ Pediatric ___ Periodontics ___ Public Health _____

Prosthodontics ___ Orthodontics ___ Oral Surgery ___ General Practice ___ Other ___

Is your practice limited? ___ Yes ___ No

Signature of Applicant

For District Use:

Approved by Executive Council (if required) _____ **(Date)**

Elected to Membership _____ **(Date)**

District Secretary-Treasurer