

MEMBERSHIP APPLICATION
OREGON DENTAL ASSOCIATION/AMERICAN DENTAL ASSOCIATION
DENTAL SOCIETY

INSTRUCTIONS TO APPLICANT: Please print clearly. Each question must be answered fully. Fax completed application to 503-218-2009

Name _____ DDS ___ DMD ___ Other ___
First Middle Last

Date of Birth _____ Social Security number _____ Sex M ___ F ___

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

Primary Office Address _____
Address Telephone

_____ City State Zip Fax

Office Email _____ Website _____

Home Address _____
Address Telephone

_____ City State Zip Fax

Home Email _____

Directory Listing Address: Office _____ Home _____

(The address chosen above will be listed on the public portion of the ODA website under "Find A Dentist", retired dentists are listed under the member portion only of the ODA website)

Preferred Mailing Address: Office ___ Home ___ Preferred Email Address: Office ___ Home ___

Prefer to receive ODA communications (check only one): Email ___ Mail ___

Prefer to receive Membership Matters newsletter via (check only one): Email ___ Mail ___

Dental School _____ Graduation Date ___/___/___
mm dd yyyy

Advanced Education Program _____ Completion Date /___/___
mm dd yyyy

Is your practice limited to a specialty? Yes ___ No ___ Specialty _____

American Board Certified? Yes ___ No ___ Oregon License _____ Year _____

Are/Were you a member of American Student Dental Association (ASDA) Yes ___ No ___ If yes, from _____ to _____
yyyy yyyy

Are you presently a member of the ADA? Yes ___ No ___ ADA Membership Number _____

I am ___/was ___ a member of the following dental societies: (Give State and local societies or Federal Dental Service)

Has your license to practice dentistry ever been revoked, suspended, or limited for disciplinary reasons? Yes ___ No ___
(if yes, state facts fully on separate sheet)

If you have ever been known by another name, please state: _____

I hereby agree to abide by the By-Laws, Principles of Ethics and Code of Professional Conduct of the _____ Dental Society, the Oregon Dental Association, and the American Dental Association.

I recognize that membership in the _____ Dental Society, Oregon Dental Association, and the American Dental Association is a privilege. I further recognize these organizations are required to investigate the qualifications of applicants and maintain standards of conduct for members.

In order to perform adequately their investigatory and disciplinary functions, these organizations must be free to perform these functions without a fear of litigation by rejected applicants or disciplined members. Therefore, in exchange for their consideration of this application, I hereby release the organizations, their members, and anyone acting on their behalf from liability for damages for any acts performed in connection with the application or disciplinary process. This release includes, but is not limited to, claims for defamation, invasion of privacy, and intentional interference with business relationship, and applies regardless of the intent with which the act is performed. I hereby consent to any investigation of the facts disclosed in my application, to any disciplinary investigation, and to any statements made in connection with the application or disciplinary process, by whomever made and whether defamatory or not.

Signature _____ Date _____

FOR COMPONENT USE ONLY

Dental Society _____

Applicant Name _____

Date Application Submitted to component: _____

(Date) **APPROVED**

(Date) **DISAPPROVED**

SIGNED BY _____
(Signature of authorizing officer or Executive Director of Component Society)

PLEASE FORWARD THIS COMPLETED FORM TO THE ODA CENTRAL OFFICE, VIA FAX TO 503-218-2009, IMMEDIATELY AFTER ELECTION TO MEMBERSHIP.