



COLLIER COUNTY DENTAL ASSOCIATION APPLICATION FOR MEMBERSHIP

Name _____

Office Address _____ Phone _____

Home Address _____ Phone _____

Family members: (Spouse) _____
(Children) _____

Dental School Attended _____

Graduation Date _____ Degree _____

Florida License Number _____ Year Obtained _____

FDA/WCDDA member: YES or NO

License and/or practice in other states? YES or NO

If yes, where _____

License revoked or suspended in any state? YES or NO

If yes, where _____

Practice limited to specialty? _____ Field? _____

Are You A:

New Member _____ Reinstated FDA Member _____

Transfer _____ Which State? _____

Jr. ADA Member _____ Current _____ Last Yr. Held _____

ADA Member _____ Current _____ Last Yr. Held _____

Former ADA Member _____ What Year(s) _____

Are You:

Engaged in Public Health _____ Administration _____

Education _____ Institutional Service _____

Other Dental Activity or Another Practice _____

Where? _____

I believe the above information to be true and correct in every aspect and have not knowingly answered falsely on any subject.

Applicant's Signature

Date