

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 # _____ DMD DDS

NAME _____

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

Single Married _____
MARITAL STATUS SPOUSES' NAME

DENTAL SCHOOL _____ YEAR OF GRADUATION _____

ADVANCED EDUCATION _____ YEAR OF GRADUATION _____

Endo Pediatric Perio Public Health Prosthodontics Orthodontics 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

COMPONENT SOCIETY _____ NAME OF APPLICANT _____ Elected Rejected

BY ACTION OF _____ AT A MEETING HELD ON _____