AADA Membership Application

Please Print Clearly

Applicant Name_____ Spouse's Name_____

Home Address_____

City, State _____ Zip _____

Cell Phone: _____ E-Mail*_____

*For you to receive information. Used solely for membership information and not sold to third parties.

I would like to ☐ JOIN or ☐ RENEW as

☐ National/State Member (married to an ADA member)	$50
☐ Contributing Member	$50
☐ Student Spouse Member (married to an ASDA member)	$5
☐ Student Contributing Member	$5

Mail this form with check payable to *AADA* or email this form with credit card info below:

Alliance of the American Dental Association
P.O. Box 1982
Brandon, FL 33509
Ph: 813-540-2154, Fax: 813-315-7132

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
☐ Practice management information
☐ Meeting people with similar concerns
☐ Well-being of the dental family
☐ Right now, only as a supportive member
☐ Having a mentor/buddy

Student Spouse DENTIST Information

Dental School_____Graduation Year _____
Graduation Year

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

Home Address_____

City, State _____ Zip _____

Credit Card #_____ Exp _____ Code _____

Billing Address _____City, State_____ Zip _____

Signature_____