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APPLICATION FOR MEMBERSHIP TO
COLORADO SPRINGS DENTAL SOCIETY, COLORADO DENTAL
ASSOCIATION, AND THE AMERICAN DENTAL ASSOCIATION

Name _____ ADA# _____

Main office address _____ Phone _____

City, state, zip _____

Home address _____

(Please circle either office or home address to indicate which mailing address CSDS should use.)

Alternate office address _____ Phone _____

_____ private practice _____ associate with _____

Date of birth _____ Male _____ Female Spouse's name _____

Dental school _____ Date of graduation _____

Degree _____ ADA-recognized specialty _____

Graduate school _____ Date of graduation _____

Were you a student member of ADA during your junior and senior years in dental school?

_____ no _____ yes

Internship (full address needed) _____

Dates _____

Residency (full address needed) _____

Dates _____

Date of licensure in Colorado _____ Colorado license number _____

Licensed in other states _____ number(s) _____

If you are a previous member of a state and a local society, give names:

Malpractice insurance carrier _____

Military service branch _____ Dates served _____

If you are or if you have ever been a direct member of ADA through the Federal Dental Service, give service _____ and years of membership _____.

References: (Provide the complete names and addresses of four PROFESSIONAL references. The CSDS does write to these people for letters of reference.)

- 1.
- 2.
- 3.
- 4.

Hospital Staff Privileges: Contact the hospitals directly. Centura Health requires applicants to complete their application form, while Memorial Hospital has been accepting a copy of this application.

In making this application, I understand that it may be used and reviewed by a hospital credentials committee (upon your authorization), by the Colorado Springs Dental Society, the Colorado Dental Association, and the American Dental Association. If granted membership in the CSDS, I agree to abide by the bylaws and the Code of Ethics of the American Dental Association.

I hereby give consent for copies of my application to be forwarded to Memorial Hospital (upon your authorization) and to the CDA and to the ADA. I also give consent for the CSDS to verify information I have provided and to contact my references for letter of recommendation.

Date _____ Your signature _____

Procedure:

Return your application to the Colorado Springs Dental Society along with a check for \$20.00 for the application fee. A dentist is considered a member when the dues for the current year have been paid, when the application process is completed, and when the CSDS Board has approved you for membership. Your name will be printed in our newsletter as a new member, and your name will be forwarded to the Membership Committee and to the New Dentists' Forum.

Dues: ADA _____ CDA _____ CSDS _____

Please note that Disability Income Specialists does require dues to be paid before they will insure you.

Please include a passport-size photo with this application.