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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.**

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**I**n 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 \_\_\_\_\_

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**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.