



AFFILIATE MEMBER Application Form

Affiliate membership is available to dentists who are members of the ADA and reside in a state other than Minnesota. The membership fee for 2019 is \$125.00, payable to the Minnesota Dental Association. Please complete all information. Thank you.

ADA Number _____ - _____ - _____
Name _____ Sex M ___ F ___ Date of Birth ___/___/_____
Office address _____
City _____ County _____ State _____ Zip _____
Phone Number (____) _____ Fax Number (____) _____
Home address _____
City _____ County _____ State _____ Zip _____
Phone Number (____) _____ Fax Number (____) _____
Please indicate if you prefer to have mail sent to: Home _____ Office _____
E-mail address _____
Dental School _____ Graduation Date ___/___/_____
Degree _____

Please indicate license status: ___ Presently Licensed, License Number _____ State _____
___ License Pending _____ <i>(please state reason)</i>

I maintain my ADA membership through: _____ <i>(Please indicate State Dental Association)</i>

I hereby apply for affiliate membership in the Minnesota Dental Association and resolve to abide by the Bylaws and the Code of Ethics and Professional Conduct if accepted into membership.

Signature _____ Date ___/___/_____

Please return to: Minnesota Dental Association
ATTN: Membership
1335 Industrial Blvd, Minneapolis, MN 55413
(612) 767-8400 (800) 950-3368
Email: djensen@mndental.org