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 **2024** 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 _____
(please state reason)

I maintain my ADA membership through:

_____
(Please indicate State Dental Association)

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