PINELLAS COUNTY DENTAL ASSOCIATION

2473 FOURTEENTH AVENUE NORTH
ST. PETERSBURG, FLORIDA 33713-5835

(PLEASE TYPE OR PRINT AND FILL-OUT INCLUDING ALL SIGNATURES)

I hereby make application for membership in the Pinellas County Dental Association and agree to abide by the By-Laws of the organization.

I understand that my membership in the Pinellas County Dental Association will be provisional for a period of one year, upon acceptance and that active status is dependent upon membership in the West Coast District Dental Association, The Florida Dental Association and the American Dental Association during this one year period.

FULL NAME_____ DATE OF BIRTH_____

OFFICE ADDRESS_____ ZIP_____ PH:( )_____

RESIDENCE ADDRESS_____ ZIP_____ PH ( )_____

OFFICE EMAIL_____ HOME EMAIL_____

SPOUSE'S NAME_____ SPOUSE'S BUSINESS PHONE:( )_____

PLACE OF BIRTH_____ DEGREES EARNED_____

DENTAL COLLEGE_____ YEAR GRADUATED_____

SPECIALTY_____ YEAR_____ BOARD CERTIFIED_____

PREVIOUS MEMBERSHIP IN OTHER LOCAL DENTAL ASSOCIATION (CITY) _____

SOCIAL SECURITY NUMBER _____ YEAR OF FLORIDA BOARD_____

FLORIDA LICENSE NUMBER_____ OTHER STATE LICENSE NUMBER_____

The privilege of membership in the Pinellas Dental Association entails the responsibility of participation in the activities of The Association.

ENDORSED BY: (2 members of the PCDA with a minimum of 2 years of membership and with whom you are not in practice.)
PLEASE PRINT NAME AND SIGN NAME

1._____ DATE _____
PRINT NAME

1._____ APPLICANT'S SIGNATURE BELOW
SIGN NAME PLEASE PRINT NAME AND SIGN NAME

2._____ _____
PRINT NAME *PRINT NAME*

2._____ _____
SIGN NAME *SIGN NAME*

Send to the above address along with your dues check

in the amount of $_____

(TYPE OR PRINT)

PHOTO