



**BIOGRAPHICAL continued**

If practicing in other than a solo practice, please indicate the group or practitioner's name and location:

Name \_\_\_\_\_

Street \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Please indicate if licensed:  Presently  Pending \_\_\_\_\_

If licensed please list license number(s) and state(s)

**MEMBERSHIP**

Are/were you a member of the American Student Dental Association?  Yes  No If yes, from \_\_\_\_\_ to \_\_\_\_\_

Please indicate your membership status in the American Dental Association:

Current member in \_\_\_\_\_ with dues paid for the \_\_\_\_\_ membership year  
State Society Year

Was previously a member in \_\_\_\_\_ from \_\_\_\_\_ to \_\_\_\_\_  
State Society Year Year

**APPLICANT SIGNATURE**

I hereby apply for tripartite membership in the American Dental Association and resolve to abide by the *ADA Bylaws and the Principles of Ethics and Code of Professional Conduct* if accepted into membership.

Signed \_\_\_\_\_ Date \_\_\_\_\_



Please send your application to the Idaho State Dental Association,  
1220 W. Hays Street, Boise, ID 83702  
Phone: (208) 343-7543; Fax number (208) 343-0775  
info@theisda.org

