## Application for Associate Membership

# SECOND DISTRICT DENTAL SOCIETY OF NEW YORK

**Name:** _____
**(Last)** **(First)** **(Middle)**

**Date of Birth:** _____ **Gender:** (circle one) **M F** **ADA#:** _____

**Home Address:** _____ **Phone:** _____
_____ **Fax:** _____
_____ **Email:** _____

**Office Address:** _____ **Phone:** _____
_____ **Fax:** _____
_____ **Email:** _____

**Preferred Mailing Address:** (circle one) **Home Office**

**Is the practice a professional corporation:** **Yes No** **Do you also practice at other locations:** **Yes No**

**Type: General** **Practice limited to** _____ **Board Certified:** **Yes No** (Please submit documentation)

**EDUCATION:** **School** **Degree** **Grad. Year**

**Dental:** _____

**Postgraduate:**_____

**Hospital, Internship, Residency and Military affiliations, past and present (include dates started, completed and documentation):**_____
_____

**NY State License #:** _____ **Date Licensed:** _____

**Are you currently registered with the NYS Dept. of Education:** (circle one) **Yes No** (Please submit documentation)

**Were you ever convicted of a felony or disciplined by a state board for dentistry or a state regents board: Yes No**
**(if Yes, explain):**_____

**Current or previous affiliations with dental associations (describe, note dates & ID/ADA #):**
_____
_____

**Were you ever rejected, deferred or suspended by a state or component society of the ADA? Explain:**
_____

I hereby state that I will conduct my practice in accordance with the Code of Ethics. If at any time I should violate the Code of Ethics, it is understood that my membership may be forfeited in the Second District Dental Society. If elected to membership, I agree to comply with all Bylaws, Codes of Ethics, and other Rules and Regulations of the Second District Dental Society and the American Dental Association.

Date:_____ Signature:_____

**111 FORT GREENE PLACE BROOKLYN, NY 11217 TEL: (718) 522-3939 FAX: (718) 797-4335**

**(REV. 7/02)**