MEMBERSHIP APPLICATION


American Dental Association

# KENTUCKY DENTAL ASSOCIATION

Local Dental Society

1920 Nelson Miller Parkway • Louisville, KY 40223
800-292-1855 • 502-489-9121

**ADA ID Number (If Known)** _____

Name _____ Maiden Name _____

**Office Address** _____ Suite _____ County of Practice _____

City _____ State _____ Zip _____

Phone (____) _____ Fax (____) _____ Date of Birth _____

**Home Address** _____ Apt. No _____

City _____ State _____ Zip _____ County _____

Phone (____) _____ Spouse's Name _____

All mail should be sent to ☐ Office or ☐ Home

E-mail Address _____ ☐ Office or ☐ Home

Website _____

Dental School _____ Year of Graduation _____

Type of Degree _____ Specialty _____

Specialty Board Certification _____ Year _____

License Presently ☐ Pending ☐ License # _____ State _____

Are you currently a member of the ADA? ☐ Yes ☐ No If yes, from _____ to _____

Are you currently a full-time Graduate Student? ☐ Yes ☐ No

Current or past Graduate School or Hospital _____ Specialty or Major _____

City _____ State _____ Starting Date _____ Completion Date _____

I hereby apply for membership in the American Dental Association, the Kentucky Dental Association and my local society and resolve to abide by the Bylaws and Code of Ethics and Professional Conduct if accepted into membership.

Signature _____ Date _____

**Remember to keep the KDA office informed of any changes in office and home information!**

Please return application to:

Membership Services
Kentucky Dental Association
**kda@kyda.org**