South Dakota DENTAL ASSOCIATION

A CONSTITUENT OF THE AMERICAN DENTAL ASSOCIATION

Allied Membership Application

804 N Euclid; Ste 103; Pierre SD 57501 • 605-224-9133 • Fax 605-224-9168 email: info@sddental.org • www.sddental.org

*(Please print **or type**)* I hereby make application for membership in the South Dakota Dental Association.

Name: _____
(last) (first) (middle)

Date of Birth: _____ Hygienist Assistant Office Manager Office Staff (Circle one)

Home Address: _____

City _____ State _____

Zip _____

Home Phone: _____

Use as my primary mailing address ☐

Office Address: _____

City _____ State _____

Zip _____ County _____

Office Phone: _____

Office Fax: _____

Use as my primary mailing address ☐

Primary Email Address (This is required; your application will be returned without an email): _____

Dental Education Program

School _____ City _____ State_____

Year of Graduation _____

Date of Licensure in South Dakota _____ South Dakota License # _____

Licensed in the following state(s) _____

Personal

Marital Status Married Single

Spouse's Name (include last name if different) _____

Are you interested in volunteering for community presentations, oral screenings, and health fairs?
yes no not at this time

Enclosed is my completed application and check # _____ made payable to:

South Dakota Dental Association
PO Box 1194
Pierre SD 57501

Please charge my $100.00 dues to the following card:
☐ Visa ☐ MC ☐ Discover ☐ American Express
(please check one)

Card # _____ _____ _____ _____

Expires _____ 3 digit code _____

Name on Card (please print) _____

Signature _____

**To qualify for free Annual Session registration and reduced fees for other SDDA CE, all applications MUST be received by NO LATER than March 1st of each year..*

(feel free to make copies)