

HYGIENE MEMBER APPLICATION

PROFESSIONALS UNITED FOR ORAL HEALTH CARE



Contact Information

Name _____

Address _____

City _____ State _____ ZIP _____

Home phone _____ Fax _____ E-mail _____

Employer _____

Employer's address _____

City _____ State _____ ZIP _____

Office phone _____ Fax _____ E-mail _____

Is your employing dentist an FDA member? Yes No

Type of Employment

Private practice – General Private practice – Specialty _____

Clinic Faculty/teaching Full time Part time Not employed

Background

Educational program _____

Degree _____ Date of licensure _____

Florida License No. _____ Years of practice in Florida _____

Areas of special interest _____

Do you typically attend the Florida National Dental Convention? Yes No

What courses or programs would interest you? _____

Other professional memberships _____

Signature _____

Date _____

Please return this form to:
Florida Dental Association
1111 E. Tennessee St. • Tallahassee, FL 32308-6914
Phone: (800) 877-9922 • (850) 681-3629
Fax: (850) 201-5013
E-mail: membership@floridadental.org

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|--|--|
| Dues amount: \$45 | |
| <input type="checkbox"/> Check enclosed | |
| <input type="checkbox"/> Credit card payment | <input type="checkbox"/> Visa <input type="checkbox"/> MasterCard <i>(only these credit cards are accepted)</i> |
| Acct. # _____ | |
| Name on card _____ | |
| Expiration date _____ | |
| Signature on card _____ | |