



New York County Dental Society
6 East 43rd Street - 11th Floor
New York, New York 10017
212-573-8500 Fax: 212-573-9501
www.nycdentalsociety.org

APPLICATION FOR ASSOCIATE MEMBERSHIP

Please complete and return this application with your check in the amount of \$60.00

Name: _____ Gender M F

ADA#: _____ License #: _____

Office Address: _____

Telephone: _____ Fax: _____

Email: _____ Date of Birth _____

Home Address: _____

Telephone: _____ Fax: _____

Email: _____

To which address would you prefer to have your mail sent? Home Office

Dental Society in which you are currently active: _____

Dental School attended: _____ Year Graduated: _____

Indicate Specialty Designation: (please circle one)

Endodontist
Pedodontist

General Practitioner
Periodontist
Oral and Maxillofacial Radiology

Orthodontist
Prosthodontist

Oral Surgeon
Public health

If elected to Associate Membership, I agree to comply with all By-laws, Code of Ethics, Rules and Regulations of the New York County Dental Society.

Date: _____ Signature: _____