



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 GRADUATE STUDENT MEMBERSHIP

Name: _____ Gender M F

ADA#: _____ Soc. Sec #: _____

Date of Birth: _____ NY State License #: _____

Home Address: _____

Telephone: _____ Fax: _____

Email: _____

Dental School: _____ Graduation Date: _____

Advanced Degree/Hospital: _____ City/State: _____

Program Start Date: _____ Completion Date: _____

Payment: Please check your choice of dues...

Tripartite Dues \$50 ADA only \$30 NYSDA only \$10 NYCDS only \$10

If elected to Graduate Student Membership, I agree to comply with all By-laws, Code of Ethics, Rules and Regulations of the New York County Dental Society. I understand that if I have chosen not to pay dues to the American Dental Association, I will not be eligible for ADA reduced dues upon completion of my residency.

Date: _____ Signature: _____

This section MUST be completed before application can be processed.

This is to verify that the above named dentist is currently enrolled in the above advanced education program.

Signed: _____ Date: _____

Program Director or Registrar's Stamp Here