Tripartite Membership Application

For membership in the American Dental Association, Ohio Dental Association, and local dental societies.

OHIO DENTAL ASSOCIATION
ADVOCATE. INFORM. SERVE.

Thank you for your interest in becoming a member of organized dentistry! The American Dental Association, Ohio Dental Association and your local dental society have a tripartite membership structure meaning it provides you with membership at all three levels: national, state and local. Upon receipt of your application you will be provided with complete information regarding tripartite membership dues. Additional information may be requested in order to complete the application process. **Return completed applications to the ODA: online at www.oda.org; email to membership@oda.org; fax to 614-486-0381; or complete and mail to Ohio Dental Association, 1370 Dublin Road, Columbus, OH 43215.**

**Indicates a required field*

GENERAL INFORMATION:

Prefix | First Name* | Middle/Maiden Name | Last Name* | Suffix

Date of Birth* | Gender* | Marital Status | Spouse's Name | Race/Ethnicity

CONTACT INFORMATION:

Please indicate if you prefer correspondence to be sent to: ☐ Office ☐ Home

Home Address* | City | State | Zip

Office Address* | City | State | Zip

Home Phone | Office Phone | Office Fax

Home Email Address | Office Email Address | Website URL

Please indicate which address you would like to use to determine your component dental society: ☐ Office ☐ Home

Membership in a component dental society is based on the county where the dentist is engaged in practice or resides.

EDUCATIONAL HISTORY:

Dental School* | Graduation Year* | Degree Type

Advanced Educational Program

School/Hospital | Specialty | Start Year/End Year

School/Hospital | Specialty | Start Year/End Year

Is your practice limited to a specialty?: ☐ Yes, please list _____ ☐ No, general practice

ADDITIONAL INFORMATION:

ADA Number | Dental License Number | ASDA Member? Yes/No

What is your current working arrangement:

☐ Solo ☐ Small Group ☐ Large Group ☐ Partnership ☐ Associateship ☐ Federal Dental Service ☐ Clinic ☐ Faculty

What is your primary reason for joining organized dentistry? (Select all that apply)

☐ Information ☐ Representation ☐ Discounted Products/Services ☐ Networking/Fellowship ☐ Public Service

How would you like to receive ODA membership communications? (i.e. annual dues statement)

☐ Communications electronically ☐ Communications via mail

STATEMENT AND SIGNATURE:

By signing below, I agree that the information provided within this application is true to the best of my knowledge. Once membership is approved, I also agree to abide by the American Dental Association Principles of Ethics and Code of Professional Conduct.

Signature | Date: