PINELLAS COUNTY DENTAL ASSOCIATION

Application for Membership

I hereby make application for membership in the Pinellas County Dental Association and agree to abide by the By-Laws of the organization.

I understand that my membership in the Pinellas County Dental Association will be provisional for a period of one year, upon acceptance and that active status is dependent upon membership in the West Coast District Dental Association, The Florida Dental Association and the American Dental Association during this one year period.

Full Name: ______________________________ Date of Birth: ____________ Degree: DMD DDS

Office Address: ____________________________ City: ______________St: _____ Zip: ________

Phone: ________________Fax: ________________

Email: ____________________________ Website: ____________________________________

Home Address: ____________________________ City: ______________St: _____ Zip: ________

Phone: ________________Fax: ________________ Email: ____________________________

Preferred Mail: OFFICE HOME Spouse Name: ______________________ Spouse a Dentist? YES NO

Dental School: ______________________________ Date of Completion: ___________________

Specialty: ___________________________ Date of Completion: __________ Board Certified: YES NO

Previous Membership in Other Local Dental Association: ____________________________

Florida License Number: _______________ License in Other State(s): _______________

Please tell us how you heard about the Pinellas County Dental Association and why you chose to join
____

The privilege of membership in the Pinellas Dental Association entails the responsibility of participation in the activities of The Association.

__________________________________ __________

APPLICANT SIGNATURE DATE

Dues Paid
$_____________

Send the signed application, and dues payment to the address/email below.

Pinellas County Dental Association

P.O. Box 1833 * Brandon, FL 33509

Phone: (727) 342-0374 Fax: (727) 342-6842

smilepinellas@gmail.com www.smilepinellas.com

PINELLAS COUNTY DENTAL ASSOCIATION

Payment Information

Name(s): ____

Payment Method: Credit Card ☐ Check: Made payable to PCDA ☐

Credit Card No: ____ Exp. Date: ______

Billing Address: ____

City: ____ State: _____ Zip Code: __________

Signature: ___________________________

Total $ _______________

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