

Upper Pinellas County Dental Association
P.O. Box 611, Brandon, FL 33509 Phone: (727) 449-1232 ♦ Fax: (813) 654-2505

Membership Application

Name: _____ Nickname: _____

Office Address: _____

City: _____, FL Zip: _____ Website: _____

Office Phone: (____) _____ Fax: (____) _____ E-mail: _____

2nd Office Address: _____ City: _____, FL Zip: _____

Office Phone: (____) _____ Fax: (____) _____

Home Address: _____ Spouse's Name: _____

City: _____, FL Zip: _____ Home Phone: (____) _____

Academic Training

Dental School: _____ Degree: _____ Year Graduated: _____

Post Graduate: _____

Board Certification: _____ Year: _____

National and State Licenses

State Licenses (include year): _____

National Licenses or boards (include year): _____

Chronological History of Practice Since Graduation

1. _____

2. _____

3. _____

4. _____

Practice: Solo ☐ Associate ☐ with _____ Other ☐ (explain): _____

Over →

Have you ever had patient complaints to any Professional Relations Committee?

Yes No If yes, give details _____

Have you ever been investigated by the Department of Professional Regulations?

Yes No If yes, give details _____

Have you ever been convicted of a felony?

Yes No If yes, give details _____

Have you ever been arrested for drug abuse?

Yes No If yes, give details _____

Have you ever had your license suspended?

Yes No If yes, give details _____

Have you ever been reprimanded for ethical misconduct?

Yes No If yes, give details _____

Have you belonged to other dental associations?

Yes No If yes, give details _____

I certify the above information to be true.

I certify that I will abide by the Articles of Incorporation and By-Laws of the Upper Pinellas County Dental Association. I authorize the Upper Pinellas County Dental Association Membership Committee to seek information concerning the above questions for use in considering my candidacy for membership in the Association. I certify that I am an ethical practitioner of dentistry.

Note: Applicants must be a member of the West Coast District Dental Association.

Date of application to WCDDA: _____

Applicants Signature: _____ Date: _____

☐ **Check: made payable to UPCDA**

☐ CC # (V/MC): _____ Exp: _____ CVV Code: _____

Return Application to:
UPCDA
P.O. Box 611
Brandon, FL 33509
(727) 449-1232
Fax (813) 654-2505