Nevada Dental Association
8863 W. Flamingo Road, Suite 102, Las Vegas, NV 89147-8718 Toll Free: 800-962-6710, 702-255-4211 Fax: 702-255-3302

APPLICATION FOR TRIPARTITE MEMBERSHIP

Date of Application: _____ **Date of Birth:** _____

Full Name: _____ **DDS** ☐ **DMD** ☐ **MD** ☐

****Office Address**: _____**Suite#**:_____

City: _____ **State**: _____ **Zip**: _____

Office Phone: ( ) _____ **Office Fax:** ( ) _____

****Home Address:** _____

City: _____**State:** _____ **Zip:** _____ **Mobile:** _____

***** PLEASE CHECK THE ADDRESS BEING USED AS YOUR PRIMARY MAILING ADDRESS: OFFICE** ☐ **HOME** ☐

Spouse Name (if applicable): _____ **Specialty (if any)**: _____

Email: _____ **Website Address**: _____

Nevada Dental License #: _____ **(required)** **ADA#:** _____

Are you licensed in other States? Yes ☐ **No** ☐ **State & License #** _____

Dental Education

Undergraduate School: _____ **Month/Year of Graduation**: _____

Dental School: _____ **Month/Year of Graduation**: _____

Post Graduate School: _____ **Month/Year of Graduation**: _____

Referred by: _____

******Membership will not become effective until this application has been approved by the Officers of the Component Societies******

I hereby apply for tripartite membership and resolve to abide by the Bylaws and Principles of Ethics and Code of Professional Conduct if acted into membership.

Signed: _____ **Date**: _____

******To be completed only if you authorize Nevada Dental Association to charge the current years dues owed at time of application:***

Name on Credit Card: _____

Billing Address: _____

City: _____ **State**: _____ **Zip**: _____

C.C.#: _____

Exp. Date: _____ **CVV Code**: _____ **Signature**: _____

This application for membership was presented to the: _____ on ___/___/_____

WAS APPROVED: ☐ DISAPPROVED: ☐ : _____