

Southwestern Society of Pediatric Dentistry

APPLICATION FOR MEMBERSHIP

Date _____

NAME _____
(Last) (First) (Initial)

OFFICE _____
(Number and Street) (City) (State) (Zip Code)

TELEPHONE (_____) FAX (_____) E-MAIL _____

RESIDENCE _____
(Number and Street) (City) (State) (Zip Code)

TELEPHONE (_____) BIRTH: Month _____ Day _____ Year _____ Place _____

SPOUSE _____ CHILDREN & DOB _____

Please send my mail to (circle one) HOME OFFICE

PROFESSIONAL TRAINING

DENTAL - Institution: _____ Graduation Year _____ Degree _____

ADVANCED PEDIATRIC DENTISTRY

Institution: _____ Graduation Year _____ Degree _____

BOARD CERTIFICATION - Date _____

OTHER ADVANCED TRAINING

Institution: _____

MEMBERSHIP IN PROFESSIONAL ORGANIZATIONS AND BOARDS

- ADA AAPD
- STATE DENTAL ASSOCIATION STATE PEDIATRIC SOCIETY: _____
- LOCAL ADA SOCIETY: _____
- LOCAL Pediatric Society or Study Club: _____

I hereby verify that the above information is correct. _____

Applicant Signature _____ Date _____

APPLYING FOR MEMBERSHIP IN THE FOLLOWING CATEGORY

- ACTIVE (\$100) Life (65 Years of Age plus Attendance at 10 Annual Meetings (\$ 0)
- ASSOCIATE (\$50) Student (\$ 0)
- AFFILIATE (\$50)

*Complete and return this application with appropriate dues amount to SWSPD:
10032 Wind Hill Dr,
Greenville, IN 47124
Fax: 812-923-2900*