BREVARD COUNTY DENTAL SOCIETY, INC.
APPLICATION FOR MEMBERSHIP

PLEASE FILL ALL BLANKS. IF QUESTION DOES NOT APPLY, PLEASE INDICATE.

Thank you for your interest in membership. A dentist who is licensed to practice dentistry in Florida, is actively practicing dentistry in the State of Florida and is a member in good standing of the American Dental Association, the Florida Dental Association, and the Central Florida District Dental Association is eligible to become an Active member of the Brevard County Dental Society.

ADA NUMBER: _____________FLORIDA LICENSE #: _______________DATE OF BIRTH: ______________

FLORIDA PERMIT #: ___________________ LICENSES HELD IN OTHER STATES: ____________________

INDICATE PRIMARY MAILING ADDRESS: OFFICE HOME

NAME: ____DEGREE(S): __________________

PRACTICE NAME: ____

ADDRESS (OFFICE): ____

(If you have more than one practice, please attach a separate sheet of paper with addresses & phone numbers.)

TELEPHONE: _________________FAX NUMBER: _____________________CELL: _______________________

EMAIL ADDRESS: _____________________________WEBSITE: ____

HOME ADDRESS: ____

SPOUSE'S NAME: ____________________________ IS SPOUSE A DENTIST: YES NO

EDUCATION:

____

COLLEGE/UNIVERSITY GRADUATION DATE DEGREE/CERT.

____

DENTAL SCHOOL GRADUATION DATE DEGREE/CERT.

POST-GRADUATE PROGRAM:_______________________________YEAR LICENSED:_____________________

PRACTICE LIMITED TO:_______________________________BOARD CERTIFICATION:____________________

HISTORY OF PRACTICE SINCE GRADUATION:

____

NAME LOCATION DATES

Associate: _____Employee: _____ Partner: _____Solo______

____

NAME LOCATION DATES

Associate: _____Employee: _____ Partner: _____Solo______

____

NAME LOCATION DATES

Associate: _____Employee: _____ Partner: _____Solo______

____

SIGNATURE **DATE**