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