



ALLIED DENTAL HEALTH PROFESSIONAL MEMBERSHIP APPLICATION

Profession Hygienist Assistant Office Personnel Technician Other _____

Name _____ Sex F M
Last First MI Designation

Primary Email _____

PRIMARY OFFICE

Practice Name _____
Street Suite or PO Box

Address _____
Street Suite or PO Box

City State Zip

Phone _____ Fax _____ Website _____

HOME ADDRESS

Address _____
Street Suite or PO Box

City State Zip

Phone _____ Fax _____

PROFESSIONAL INFORMATION AND INTERESTS

License # or Certificate Type _____ State(s) _____

Please forward me information on how to participate in the following area(s) to benefit my profession:

- | | |
|---|--|
| <input type="checkbox"/> Membership recruitment | <input type="checkbox"/> Dental health presentations |
| <input type="checkbox"/> Volunteer opportunities (including Yankee Dental Congress) | <input type="checkbox"/> MDS Mobile Access to Care Van (MAC) |
| <input type="checkbox"/> Continuing education | <input type="checkbox"/> Other (specify) _____ |

PAYMENT METHOD

Annual membership dues are \$35: Enclosed is my check payable to MDS Charge my: MC/VISA/AMEX below

Credit Card # _____ Exp Date _____

Signature _____ Date _____

**Please return by mail or fax to:
Massachusetts Dental Society • Two Willow Street #200 • Southborough, MA 01745
Fax 508-480-0002 • Apply online at www.massdental.org**