



**Massachusetts Dental Society
Allied Dental Health Professional (ADHP)
Group Membership Application**

Please register the following member(s) of my staff as an MDS Allied Dental Health Professional member. I understand the annual dues for each staff member is \$35.

Office Information

Dentist Name:
Practice Name:
Address:
City, State, Zip:
Phone: _____ Fax: _____

Membership Information

<i>Full Name</i>	<i>Profession</i>	<i>Email Address</i>	<i>License/Certificate</i>

Payment Information

Total members: _____ x \$35 per member = _____ total due

- Enclosed is a check payable to the MDS
- Please charge my: MC VISA AMEX

Card #: _____ Exp. Date: ____/____/____

Signature _____

**Please return by fax or mail to:
Massachusetts Dental Society, Two Willow St, Suite 200
Southborough, MA 01745
Fax: 508-480-0002**