



Nevada Dental Association  
8863 W. Flamingo Road, Suite 102, Las Vegas, NV 89147-8718 Toll Free: 800-962-6710, 702-255-4211 Fax: 702-255-3302

**APPLICATION FOR TRIPARTITE MEMBERSHIP**

Date of Application: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Full Name: \_\_\_\_\_ DDS  DMD  MD

\*\*Office Address: \_\_\_\_\_ Suite#: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Office Phone: ( ) \_\_\_\_\_ Office Fax: ( ) \_\_\_\_\_

\*\*Home Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Mobile: \_\_\_\_\_

\*\*\* PLEASE CHECK THE ADDRESS BEING USED AS YOUR PRIMARY MAILING ADDRESS: OFFICE  HOME

Spouse Name (if applicable): \_\_\_\_\_ Specialty (if any): \_\_\_\_\_

Email: \_\_\_\_\_ Website Address: \_\_\_\_\_

Nevada Dental License #: \_\_\_\_\_ (required) ADA#: \_\_\_\_\_

Are you licensed in other States? Yes  No  State & License # \_\_\_\_\_

**Dental Education**

Undergraduate School: \_\_\_\_\_ Month/Year of Graduation: \_\_\_\_\_

Dental School: \_\_\_\_\_ Month/Year of Graduation: \_\_\_\_\_

Post Graduate School: \_\_\_\_\_ Month/Year of Graduation: \_\_\_\_\_

Referred by: \_\_\_\_\_

\*\*\*Membership will not become effective until this application has been approved by the Officers of the Component Societies\*\*\*

I hereby apply for tripartite membership and resolve to abide by the Bylaws and Principles of Ethics and Code of Professional Conduct if acted into membership.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

\*\*\*To be completed only if you authorize Nevada Dental Association to charge the current years dues owed at time of application:

Name on Credit Card: \_\_\_\_\_

Billing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

C.C.#: \_\_\_\_\_

Exp. Date: \_\_\_\_\_ CVV Code: \_\_\_\_\_ Signature: \_\_\_\_\_

This application for membership was presented to the: \_\_\_\_\_ on \_\_\_\_/\_\_\_\_/\_\_\_\_

WAS APPROVED:  DISAPPROVED:  : \_\_\_\_\_