

Return to:
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Questions? (813) 447-3452
FAX: 352-608-3113
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Hillsborough County Dental Association

"Service Above All Else"

Membership Application

Name _____ Email _____

Office Address _____ City _____ Zip _____

Office Phone Number _____ Fax _____

Home Address _____ City _____ Zip _____

Home Phone Number _____ Fax _____

Please send mail to: _____ office address _____ home address

Academic Training

Dental School _____ Degree _____ Year Graduated _____

Post Graduate _____

Board Certification _____

National and State Licenses

State Licenses (include year) _____

National Licenses or Boards (include year) _____

Practice: _____ **Solo** _____ **Associate**

If associate, with whom _____

Have you ever had patient complaints to any professional relations or peer review committee? ____yes ____no

If yes, give details _____

Have you ever been investigated by the Department of Health of the Board of Dentistry? ____yes ____no

If yes, give details _____

Have you ever been convicted of a felony? ____yes ____no

If yes, give details _____

Have you ever been arrested for drug abuse? ____yes ____no

If yes, give details _____

Have you ever had an action taken against your license? ____yes ____no

If yes, give details_____

Have you ever been reprimanded for ethical misconduct? ____yes ____no

If yes, give details_____

Have you ever belonged to another dental association either in or out of state? ____yes ____no

If yes, give names, places and dates: _____

I certify the above information to be true. Signed_____

I certify that I will abide by the constitution and bylaws and the code of ethics of the Hillsborough County Dental Association. Signed_____

I authorize the Hillsborough County Dental Association Membership Committee to seek information concerning the above questions for use in considering my candidacy for membership in the above said organization.

Signed_____

I certify that I am an ethical practitioner of dentistry and hereby apply for active membership of the Hillsborough County Dental Association. I authorize the release of any information to the Membership Committee of the Hillsborough County Dental Association for its use in considering this application.

Signed_____

Be prepared to appear before the Hillsborough County Dental Association Executive Council to present your Dental School Diploma, State License and Board Specialty.

Signed_____ **Date**_____

Please make checks payable to HCDA. We accept Visa/Mastercard/American Express

Credit Card #_____ Expiration Date_____

Name it appears on card:_____

Billing Address (Street #/Zip):_____

Signature:_____

Do not fill out information below.

Date application received_____ Amount received with application \$_____ Check #_____
Date

Date referred to HCDA Committee on Membership Admissions_____

Recommendation: ____Favorable ____Unfavorable Signed_____
Chairman, Committee on Membership Admissions

Date appeared before Executive Council_____ Elected ____ Rejected

By action of the Hillsborough County Dental Association at meeting held on:

Date: _____ Secretary: _____