

MEMBERSHIP APPLICATION

OREGON DENTAL ASSOCIATION/AMERICAN DENTAL ASSOCIATION

DENTAL SOCIETY

INSTRUCTIONS TO APPLICANT: Please print clearly. Each question must be answered fully. Fax completed application to 503-218-2009

Name _____ DDS ___ DMD ___ Other ___
First Middle Last

Date of Birth _____ Preferred Name/Nickname _____ Sex M ___ F ___

Spouse Name _____ Is Spouse a dentist? Yes ___ No ___

Primary Office Address _____
Address Office Telephone _____
City State Zip Office Fax _____
 Office Email _____ Website _____

Practice Model: In order to better serve you, we'd like to know your current primary practice model. If applicable, please name the organization with which your practice is affiliated. Group practice definitions are given on the back side of this page.

- Faculty Solo Private Practice Dentist Owned and Operated Group Practice
- Dental Management Organization Affiliated Group Practice (DM: _____)
- Insurer-Provider Group Practice (Insurer: _____)
- Not-for-Profit Group Practice (Organization: _____)
- Government Agency Group Practice (Agency: _____)
- Hybrid Group Practice (Comments: _____)

Home Address _____
Address Home Telephone _____
City State Zip Home Fax _____
 Home Email _____ Cell _____

Directory Listing: Address/Phone - Office ___ Home ___ Email - Office ___ Home ___ Do not list ___ Website - Yes ___ No ___
 (The above will be listed on the public portion of the ODA website under "Find a Dentist"; retired dentists are listed under the member portion only of the ODA website)

Preferred Mailing Address: Office ___ Home ___ Preferred Email Address: Office ___ Home ___

Preferred Phone Contact: Office ___ Home ___ Cell ___

Prefer to receive ODA communications (check only one): Email ___ Mail ___

Prefer to receive Membership Matters newsletter via (check only one): Email ___ Mail ___

Education/Specialty:

Dental School _____ Graduation Date MM / DD / YYYY _____
 Advanced Education Program _____ Completion Date MM / DD / YYYY _____

Is your practice limited to a specialty? Yes ___ No ___ Specialty _____

American Board Certified? Yes ___ No ___ Oregon License _____ Year _____

Are/Were you a member of American Student Dental Association (ASDA) Yes ___ No ___ If yes, from YYYY to YYYY _____

Are you presently a member of the ADA? Yes ___ No ___ ADA Membership Number _____

I am ___/was ___ a member of the following dental societies: (Give State and local societies or Federal Dental Service)

Has your license to practice dentistry ever been revoked, suspended, or limited for disciplinary reasons? Yes ___ No ___
(if yes, state facts fully on separate sheet)

If you have ever been known by another name, please state: _____

I hereby agree to abide by the By-Laws, Principles of Ethics and Code of Professional Conduct of the _____ Dental Society, the Oregon Dental Association, and the American Dental Association.

I recognize that membership in the _____ Dental Society, Oregon Dental Association, and the American Dental Association is a privilege. I further recognize these organizations are required to investigate the qualifications of applicants and maintain standards of conduct for members.

In order to perform adequately their investigatory and disciplinary functions, these organizations must be free to perform these functions without a fear of litigation by rejected applicants or disciplined members. Therefore, in exchange for their consideration of this application, I hereby release the organizations, their members, and anyone acting on their behalf from liability for damages for any acts performed in connection with the application or disciplinary process. This release includes, but is not limited to, claims for defamation, invasion of privacy, and intentional interference with business relationship, and applies regardless of the intent with which the act is performed. I hereby consent to any investigation of the facts disclosed in my application, to any disciplinary investigation, and to any statements made in connection with the application or disciplinary process, by whomever made and whether defamatory or not.

Signature _____ **Date** _____

If an ODA Member encouraged you to join, please indicate: Name _____

ADA Group Practice Definitions

Throughout this classification, 'group' refers to two or more dentists that are somehow affiliated with each other.

Dentist Owned and Operated Group Practice: More than one dentist in a single practice that may be located at a single or multiple sites. Completely owned and operated by dentists, usually organized as a partnership or professional corporation.

Dental Management Organization (DMO) Affiliated Group Practice: A group practice that has contracted with a DMO to conduct all of the business activities of the practice that do not involve the statutory practice of dentistry, sometimes including the ownership of the physical assets of the practice.

Insurer-Provider Group Practice: A group practice that is part of an organization that both insures the health care of an enrolled population and provides their health care services.

Not-for-Profit Group Practice: A group practice that is operated by a charitable, educational, or quasi-governmental organization that often focuses on providing treatment for disadvantaged populations or training healthcare professionals.

Government Agency Group Practice: A group practice that is part of a government agency. It is organized and managed completely by the agency. All dentists are government agency employees or contractors and operate according to agency policies.

Hybrid Group Practice: A group practice that does not clearly fit into any of the above categories and can exhibit some characteristics of several of them.