MEMBERSHIP APPLICATION INSTRUCTIONS

1. Answer every question completely. Explain items in detail on a separate sheet of paper if necessary. Applications with incomplete responses to instructions 1 to 4 will be returned for completion and may delay the application process. Please print clearly.

2. If you do not currently have a practice address, please provide your home address.

3. PLEASE ATTACH/SUBMIT THE FOLLOWING:
   a. If appending a degree in addition to DDS or DMD, a legible and true copy of the diploma(s) or degree(s) conferred upon you (which must be authenticated by either the president, secretary, dean or registrar of the educational institution attended and accompanied by a certified original translation by a qualified translator if written in a foreign language);
   b. Specialty Certificate;
   c. If you qualify as a full-time faculty member, please provide a verification letter from the school;
   d. If you are currently enrolled in a residency or graduate program, provide a verification of program enrollment.

4. To receive the CDA Journal, complete the subscription form, include a check made payable to California Dental Association, and submit with your application.

5. Upon receipt of your application, you will be contacted regarding payment of dues.

6. Our goal is to process your application as quickly as possible. If you have not heard from us in 30 days, please contact your component dental society.

7. Please return completed application to your component dental society.
   To find your component dental society please call: 1.800.CDA.SMILE or search online at, www.cda.org.

San Mateo County Dental Society
240A Twin Dolphin Drive
Redwood City, CA 94065
Phone: 650.637.1121
Fax: 650.637.1166
E-mail: smcdsetta@sbcglobal.net
SAN MATEO COUNTY DENTAL SOCIETY MEMBERSHIP APPLICATION

(PLEASE PRINT CLEARLY)

1. APPLICATION TYPE:  □ Initial Application  □ Re-application  □ Indefinite Practice Address

2. PERSONAL INFORMATION

   Gender:  □ Male  □ Female

   Name: ______________________________________________________________
   ADA No.: __________________________________________________________

   Have you ever been known by any other name(s)? □ Yes  □ No  
   SSN: ______________________________________________________________
   If Yes, please provide name(s): _______________________________________
   Date of Birth: ______________________________________________________
   Year of first licensure in the U.S.: ____________________________
   Where?: __________________________________________________________
   California Dental Lic. No.: __________________________________________
   Year licensed: _____________________________________________________

   PRIMARY OFFICE ADDRESS
   Street: ___________________________ Office Phone: ___________________________ Fax: ___________________________ 
   City: ___________________________ State/ZIP: ___________________________ Cell Phone: ___________________________
   E-mail: _____________________________________________________________
   Do you practice at any additional offices? □ Yes  □ No

   SECOND OFFICE
   Street: ___________________________ Office Phone: ___________________________ Fax: ___________________________
   City: ___________________________ State/ZIP: ___________________________ E-mail: ___________________________

   HOME
   Street: ___________________________ Phone: ___________________________
   City: ___________________________ Fax: ___________________________
   State/ZIP: ___________________________ E-mail: ___________________________

   Were you referred by a current member? If yes, by whom? ___________________________

3. PRACTICE INFORMATION

   PRIMARY OFFICE  SECOND OFFICE
   a. Name of Practice: ___________________________ ___________________________
   b. Type of Practice: ___________________________ ___________________________
   c. Nature of Employment: ___________________________ ___________________________
   (i.e. owner, associate, employee, independent contractor)
   d. Owner of the Practice/Records: ___________________________ ___________________________

4. EDUCATION

   Dental School: ___________________________ ___________________________
   Internship: ___________________________ ___________________________
   Postgraduate: ___________________________ ___________________________
   State/Country: ___________________________ ___________________________
   Date: ___________________________ to ___________________________
   Degree Earned/Specialty: ___________________________ ___________________________

5. BENEFITS

   Do you have or plan to apply for TDIC professional liability coverage? □ Yes  □ No
   Do you plan to attend the next CDA Scientific Session? Spring (Anaheim) □ Yes  □ No  Fall (San Francisco) □ Yes  □ No

FOR COMPONENT USE ONLY

   Date Application Submitted to Local Society: ___________________________
   Date Application Submitted to CDA: ___________________________
   Date Application Returned From CDA: ___________________________

FOR CDA OFFICE USE ONLY

   Status: ___________________________
   Quote for Membership Year: ___________________________
   ADA Dues: $ ___________________________ CDA Dues: $ ___________________________
   Can Prorate ADA: □ Yes  □ No  Can Prorate CDA: □ Yes  □ No
   Date Quote Requested from ADA: ___________________________
   Date Quote Sent to Component: ___________________________
   Date Elected: ___________________________
6. PRACTICE INFORMATION
- I am a General Dentist
- I am a specialist in the ADA recognized specialty of ________________________________
  (Please submit a copy of specialty certificate)

7. PERMITS
Do you or your employer practice under a name other than that which appears on your license?  
- Yes  
- No
If Yes, please provide name(s) _________________________________________________________________________

If Yes and you have not already done so, you are required to obtain a fictitious name permit from the Dental Board of California:
  Telephone: (916) 263-2300, Ext. 2332  Website: www.dbc.ca.gov
  Is conscious sedation administered in your office?  
- Yes  
- No
  Permit Holder’s Name: _______________________________________________________________________________

  Is general anesthesia administered in your office?  
- Yes  
- No
  Permit Holder’s Name: _______________________________________________________________________________

  Do you write Schedule II prescriptions?  
- Yes  
- No
If yes, provide your Narcotics License Number: ___________________________________________________________

8. MEMBERSHIP AND LICENSURE DISCIPLINARY ACTION
A) Have you ever received notice that you failed to comply with or been subject to the adverse decision of a duly constituted committee of a constituent or component dental society of the American Dental Association, or is any such action pending?  
- Yes  
- No

B) Are you currently subject to any state board disciplinary action resulting from an adverse decision (suspension, probation terms, etc.) regarding your California dental license?  
- Yes  
- No

If the answer to any of the foregoing questions is “yes,” please provide full details (please attach an additional piece of paper, if necessary).

___________________________________________________________________________________________
___________________________________________________________________________________________
___________________________________________________________________________________________
___________________________________________________________________________________________
___________________________________________________________________________________________
___________________________________________________________________________________________
A. BYLAWS AND CODES COMPLIANCE AGREEMENT

I hereby agree to abide by the CDA Code of Ethics, the ADA Principles of Ethics and Code of Professional Conduct and the bylaws of the component dental society, the California Dental Association and American Dental Association.

I hereby acknowledge and agree, as to any patient I treat, to comply with the reasonable requests of a duly constituted peer review committee as set forth in Section 3 of the CDA Code of Ethics and to abide by the decisions of such body. It is understood that this may require, among other things, that I provide patient records, including x-rays, study models, or other documents necessary in order for a committee to conduct a peer review. In the event of a peer review decision in favor of the patient, funds will be made available by me as designated by the peer review decision. I also acknowledge that non-compliance with a duly constituted peer review committee, a single peer review case involving grossly inadequate or grossly inappropriate treatment, and/or a pattern of negligent or inappropriate practice (i.e., three or more adverse peer review decisions in a 24-month period), may result in the referral to the Judicial Council for investigation of possible ethical violations.

An adverse Judicial Council decision could result in a report to the Dental Board of California and the National Practitioner Data Bank, as mandated by law. In addition, such matters and violations of the CDA Code of Ethics may result in the imposition of discipline by CDA, including censure, suspension, or expulsion.

All ADA documents may be obtained at www.ada.org, all CDA documents at www.cda.org and component documents may be available from a component dental society office or website.

B. MEMBERSHIP AGREEMENT

I CERTIFY THAT all statements made by me in this application are complete, true and correct. I agree that if any such statements are found to be false, or if there are material omissions made, this application may be rejected solely on those grounds, or in the event such false statement or omission does not become known to the dental society until after I have been elected, that I may be removed immediately from membership on the basis of the false statement of omission alone. For the purposes of this paragraph, I understand that a material misstatement or omission shall mean one which is “not insubstantial” or one which is “significant in relation to the questions asked.” Upon becoming a member, I hereby waive the right to hold component dental society, CDA, ADA, or any member thereof, responsible for any damage in case of disciplinary action involving me, after a hearing in accordance with the bylaws of these organizations.

C. FAX AND EMAIL CONSENT

I understand that by providing the fax number(s) and email address(es) in Section 2 of this application, I hereby consent, on behalf of myself and on behalf of any entity specified in Section 7 of this application, to receive faxes and emails sent by or on behalf of the component dental society, California Dental Association, American Dental Association, The Dentists Insurance Company, TDIC Insurance Solutions, and California Dental Association Foundation. If I am giving this consent on behalf of an entity specified in Section 7 of this application, I hereby represent and warrant that I am duly authorized to execute and deliver this consent on behalf of that entity.

Name of Applicant (please print)

______________________________
Signature

______________________________
Date

REV 02-01-08
FOR COMPONENT STAFF USE ONLY

Applicant Name: ________________________________________________________________________________________

Application Review Checklist

Are all questions on the application answered and application signed? □ Yes □ No
Did applicant provide his/her dental license number? □ Yes □ No
Does applicant append additional degrees after his/her name?
   □ Yes □ No
   If Yes, did applicant include proper documentation?

Currently:
Has the applicant been denied membership in a component dental society? □ Yes □ No
Has the applicant been expelled or suspended for ethical reasons? □ Yes □ No
Is the applicant’s license currently subject to disciplinary action
   by the Dental Board (i.e., probation, suspension, etc.)? □ Yes □ No
Is the applicant being considered for “Conditional” membership status or denial? □ Yes □ No
Does the applicant have any unresolved Peer Review cases?
   (For transfer applicants - See Transfer Applicant Guidelines)
   □ Yes □ No

If Yes to any items in this box, mandatory referral to MARS is necessary.
Please complete the “Component Referral To MARS” form and forward the
application to MARS for review.

HELPFUL ITEMS:

DENTAL BOARD OF CALIFORNIA INFORMATION:
Telephone: 916.263.2300
Website: www.dbc.ca.gov
(Once on website, if you use the “License Verification” option, you will be able to check current license status, permits,
disciplinary actions and business ownership all on the same web page)

DEPARTMENT OF MANAGED HEALTH CARE
Telephone: 1.800.HMO.2219
Website: www.dmhc.ca.gov