



Associate Membership Application

Membership Fee: \$50. Tripartite membership in your state is required to join ISDS as an associate member. Please fill out the application below and mail to ISDS. You may include a check or your credit card information.

ADA #

Name:

Last

First

Middle

Birth Month/Day/Year

Phone

e-mail Address

Mailing address

City

State

Zip

State Dental Society Membership

Signature of Applicant

Date

Credit Card Number

Expiration Date

Billing address

Credit Card Security Code:

Please return this application to:

Illinois State Dental Society
P. O. Box 376 • Springfield, IL 62705
800/475-4737 • Fax: 800/525-8872