

**Volusia-Flagler Dental Association
Membership Application**

Date: _____

Name: _____

Date of Birth: _____

Office Address: _____

Office Phone: _____
Office Fax: _____
Email: _____

Home Address: _____

Home Phone: _____

Florida Dental License #: _____

Practice Type: General
Specialty: _____

Dental School: _____
Graduate or Specialty Training: _____
Board Certification: _____

Year Graduated: _____ Degree: _____

Are you a member of the ADA, FDA, and CFDDA? _____
ADA membership number: _____

Have you ever applied for membership to the ADA, FDA, CFDDA? _____

Branch of Armed Services: _____ M.O.S. _____ Grade: _____
In service from: _____ to _____

Spouse's Name: _____ Children's Names: _____

Endorsement: Please have this application endorsed by two members of the Volusia-Flagler Dental Association:

1. _____
2. _____

Dues for the VFDA are \$175.00 per year and are due at the time of Membership Application. Membership in the ADA, FDA, and the CFDDA are requisites for membership. If you are not yet a member of the Central Florida District Dental Association, you will be granted a Provisional Membership in the VFDA until y our initiation into the CFDDA at the annual February meeting.

Please submit this completed application to the current Secretary of the VFDA.