



## AFFILIATE MEMBER Application Form

Affiliate membership is available to dentists who are members of the ADA and reside in a state other than Minnesota. The membership fee for **2025** is \$125.00, payable to the Minnesota Dental Association. Please complete all information. Thank you.

ADA Number _____ - _____ - _____
Name _____ Sex M__ F__ Date of Birth ____/____/____
Office address _____
City _____ County _____ State _____ Zip _____
Phone Number (____) _____ Fax Number (____) _____
Home address _____
City _____ County _____ State _____ Zip _____
Phone Number (____) _____ Fax Number (____) _____
Please indicate if you prefer to have mail sent to: Home _____ Office _____
E-mail address _____
Dental School _____ Graduation Date ____ / ____
Degree _____

Please indicate license status: ____ Presently Licensed, License Number _____ State _____
____ License Pending _____ <i>(please state reason)</i>

I maintain my ADA membership through: _____ <i>(Please indicate State Dental Association)</i>
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*I hereby apply for affiliate membership in the Minnesota Dental Association and resolve to abide by the Bylaws and the Code of Ethics and Professional Conduct if accepted into membership.*

Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Please return to: Minnesota Dental Association  
ATTN: Membership  
1335 Industrial Blvd, Minneapolis, MN 55413  
(612) 767-8400 (800) 950-3368  
Email: [djensen@mndental.org](mailto:djensen@mndental.org)