Buncombe County Dental Society

Membership Application

Check One: **New Member** ☐ **Associate Member** ☐ **Honorary Member** ☐

Date: ______________

Full Name____ DDS ☐ DMD ☐

Date of Birth: ___/___/_____ Specialty: _____________________________________

NC Dental License #: ___________________ Sex: Male ☐ Female ☐

Government Employed: Yes ☐ No ☐ ADA Member: Yes ☐ No ☐

Marital Status: ____________________ Spouse Name: ___________________________________

Home Address: ____

City: _________________________ State: ______ Zip: __________________

Phone: (___) _____________ E-Mail: _______________________________________

Practice: ____

Practice Address: ____

City: _________________________ State: ______ Zip: __________________

Office Administrator: _____________________ Practice E-Mail: _____________________

Phone: (___)_____________ Fax: (___)_____________

Education:

Predental:__________________________ Degree: ______________From:_________ to:_________

Dental: ____________________________ Degree: ______________From: _________to: ________

Post Grad./Other: ____________________Degree: ______________From: _________to:_________

If elected to membership, I agree without reservation to conduct myself professionally and personally according to the principles of dental ethics and to be governed by the constitution and by-laws of the Buncombe County Dental Society.

THIS APPLICATION WAS ELECTED TO BCDS MEMBERSHIP EFFECTIVE:

____
(Signature)

____
(Buncombe County Dental Society)

____
(Date)

____
(Date)