South Dakota
DENTAL ASSOCIATION

A CONSTITUENT OF THE AMERICAN DENTAL ASSOCIATION

# Allied Student Membership Application

804 N Euclid; Ste 103; Pierre SD 57501 • 605-224-9133 • Fax 605-224-9168 email: info@sddental.org • www.sddental.org

*(Please print **or type**)* I hereby make application for membership in the South Dakota Dental Association.

Name: ______________________________________________________________
(last) (first) (middle)

Date of Birth: ______________________________ Hygiene Student Dental Assisting Student (Circle one)

Home Address: ______________________________
City ______________ State ________
Zip ____________
Home Phone: ___________________________
Use as my primary mailing address ☐

School Year Address: ___________________________
City ______________ State ________
Zip ____________
School Phone: ___________________________
Use as my primary mailing address ☐

Primary Email Address: ____________________________

## Dental Education Program

School ____________________________________ City ____________________________ State__________

Anticipated Year of Graduation _________________

## Personal

Marital Status Married Single

Spouse's Name (include last name if different) _______________________________________________

Are you interested in volunteering for community presentations, oral screenings, and health fairs?
yes no not at this time

Enclosed is my completed application and
check # __________ made payable to:

*South Dakota Dental Association*
*PO Box 1194*
*Pierre SD 57501*

Please charge my $35.00 dues to the following card:
Visa Mastercard

Card # _________ _________ _________ _________

Expires ______________ 3 digit code _____________

Name on Card (please print) __________________________

Signature ____________________________________

00sdda/NEWMEM/applications/sdda Allied Student Application