

Affiliate Membership Application

(Please type or print with ball point pen and complete all sections.)

Name: _____ Gender: F M
Last First Middle

Home Address: _____ Office Address: _____

Home Phone: (____) _____ Office Phone: (____) _____

Fax: (____) _____ Email: _____ Birth Month/Day/Year _____

Employer (name of dentist): _____ Mail to: Office Home

EDUCATION/LICENSURE

Hygiene School: _____ Year of Graduation: _____

WA Hygiene License #: DH _____ Previously licensed (state/#): _____

Have you ever had any disciplinary actions taken against you by a state agency? Yes No

Signature _____

METHOD OF PAYMENT:

Please make checks payable to the Washington State Dental Association and submit your payment of \$25 to the address below.

Check Visa MasterCard AMEX

Name on Credit Card: _____

Credit Card Number: _____ Expiration Date: ____/____/____

Card Holders Signature: _____

Washington State Dental Association
126 NW Canal St
Seattle, WA 98107
Phone: (800) 448-3368
Fax: (206) 443-9266
Email: info@wsda.org

WSDA USE

Date Processed: _____

Membership #: _____

Card Issued: _____ Staff _____

DQAC checked: _____