COMPONENT TRANSFER APPLICATION

OREGON DENTAL ASSOCIATION/AMERICAN DENTAL ASSOCIATION

INSTRUCTIONS TO APPLICANT: *Please print clearly. Each question must be answered fully.*

Name _____ DDS___DMD___Other_____
First Middle Last

Date of Birth_____ ADA Membership Number_____ Sex M___F____

If you have ever been known by another name, please state:_____

Current Component_____

New Component (if known)_____

Primary Office Address _____ _____
Address Office **Telephone**

_____ _____
City State Zip **Office Fax**

Office Email_____ Website_____

Home Address _____ _____
Address Home Telephone

_____ _____
City State Zip Home Fax

Home Email_____ _____
Cell

Directory Listing:

Address/Phone - Office ___ Home ___ Email - Office ___ Home ___ Do not list ___ Website - Yes ___ No ___
(The above will be listed on the public portion of the ODA website under "Find a Dentist"; retired dentists are listed under the member portion only of the ODA website)

Preferred Mailing Address: Office____ Home____ Preferred Email Address: Office____ Home____

Preferred Phone Contact: Office____ Home____ Cell____

Prefer to receive ODA communications (check only one): Email_____ Mail_____

Prefer to receive Membership Matters newsletter via (check only one): Email_____ Mail_____

Signature_____ **Date**_____

Component Approval Signature_____ **Date**_____

MAIL, EMAIL, OR FAX COMPLETED FORM TO:
ADDRESS: 8699 SW Sun Place**,** Wilsonville, OR 97070
FAX: 503.218.2009 **EMAIL:** members@oregondental.org