HERNANDO COUNTY
DENTAL SOCIETY
AN AFFILIATE OF THE WEST COAST DISTRICT,
AMERICAN & FLORIDA DENTAL ASSOCIATIONS

1114 Kyle Wood Lane, Brandon, Florida 33511
Phone: (352) 587-2811
Email: hernandocda@gmail.com
Website: www.hernandocountysmiles.org

Membership Application

Name:_____

Email:_____

Home Address: _____

City:_____ St:_____ Zip:_____ Phone: ( )_____

Office Name: _____ Phone: ( )_____

Office Address:_____

City:_____ St:_____ Zip:_____

Academic Training

Dental School: _____ Degree:_____ Grad Year:_____

Post Graduate: _____ Grad Year:_____

Board Certificate: _____ Year:_____

National and State Licensure

FL State License #: _____ Year:_____

Other State License #'s/Years: _____

National Licenses of Boards/Year: _____

Chronological History of Practices since Graduation:

1) _____ Year:_____

2) _____ Year:_____

3) _____ Year:_____

4) _____ Year:_____

Practice (Circle): SOLO ASSOCIATE OTHER (Explain)_____

If an Associate, with Whom? _____

Have you ever had a patient complaint to any professional relations committee? Circle: YES NO

If Yes, please explain: _____

_____

_____

Have you ever been investigated by the department of professional regulation? Circle: YES NO

If Yes, Please Explain:_____

_____

Have you ever been convicted of a felony? Circle: YES NO

If Yes, Please Explain: _____

Have you ever been convicted for drug abuse? Circle: YES NO

If Yes, Please Explain: _____

Have you ever had your license suspended? Circle: YES NO

If Yes, Please Explain: _____

Have you ever been reprimanded for ethical misconduct? Circle: YES NO

If Yes, Please Explain: _____

Please use this Area for further Explanation of the above: _____

_____

_____

_____

Have you ever belonged to another dental association either in or out of state? Circle: YES NO

If Yes, Give Names, Places, and Dates: _____

_____

I, _____, certify the above information to be true. I authorize the HCDS Membership Committee to seek information, if needed, concerning the above questions.

I understand that the Hernando County Dental Society (HCDS) is an affiliate organization of the American Dental Association, Florida Dental Association and the West Coast District Dental Association ("tripartite"). I understand that my membership in the HCDS is contingent upon my membership in good-standing of this tripartite.

I certify that I will abide by the articles of incorporation and by-laws and code of ethics of the HCDS.

Signature:_____ Date:_____

Payment Information – $225.00

Pmt. Type: Visa _____ MasterCard _____ Discover _____ Amex _____

Check Payable to HCDA (enclosed) _____

CC # : _____ Exp. Date: _____ CVV: _____

Billing Address: _____ City: _____ Zip: _____

Email to send receipt: _____

If paying by credit card add 3% convenience fee of $6.75 ($231.75 total)