

**CALIFORNIA SOCIETY OF PEDIATRIC DENTISTRY
AFFILIATE MEMBERSHIP APPLICATION**

____/____/____
Date of Application

An applicant for Affiliate membership shall be a non-pediatric dentist or physician residing in California whose interests are consistent with the mission of the Society.

Name (Last)	(First)	(MI)	e-mail address			Office Website Address (if any)	
			@				
Office # 1	Street Address	City	State	Zip	Telephone	Fax	
Office # 2	Street Address	City	State	Zip	Telephone	Fax	
Home	Street Address	City	State	Zip	Telephone	List home phone in Directory? Yes ____ No ____	
Spouse Name	List Spouse in Directory Yes ____ No ____	Preferred CSPD Mailing Address office ____ home ____		CSPD Bulletin Electronic Format Only Yes ____ No ____		Date of Birth / /	

PROFESSIONAL TRAINING (List Month & Year)

Institution	Undergraduate School		Professional School		Intern/Residency		Degree/Certificate
	From	To	From	To	From	To	

HISTORY OF EXCLUSIVE PRACTICE, TEACHING OR RESEARCH IN MEDICINE OR DENTISTRY

Dates		Place	Practice %	Teaching %	Research %
From	To				

Make checks payable to:
California Society of Pediatric Dentistry
Mail to:
CSPD (Dues Apply to the 2012 year)
PO. Box 221608
Carmel, CA 93922

Affiliate members may not use the Society name, membership status or logo, nor imply special expertise or training in pediatric dentistry.

Application Fee: \$25
First Year Dues: \$155
Total: \$180