

**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.

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|-------------|---|------|---|-----|-----------|---|--|
| Name (Last) | (First) | (MI) | Date of Birth / / | | | e-mail address @ | |
| 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 ____ | | | Office Website Address (if any) | |

PROFESSIONAL TRAINING (List Month & Year)

| Institution | Undergraduate School | | Professional School | | Intern/Residency | | Degree/Certificate |
|-------------|----------------------|----|---------------------|----|------------------|----|--------------------|
| | From | To | From | To | From | To | |
| | | | | | | | |
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HISTORY OF EXCLUSIVE PRACTICE, TEACHING OR RESEARCH IN MEDICINE OR DENTISTRY

| Dates | | Place | Practice % | Teaching % | Research % |
|-------|----|-------|------------|------------|------------|
| From | To | | | | |
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Make checks payable to:
California Society of Pediatric Dentistry
Mail to:
CSPD (Dues Apply to the 2011 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
Annual Dues: \$155
Total: \$180