

**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)	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	

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

Dates		Place	Practice %	Teaching %	Research %
From	To				

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

Make checks payable to:  
California Society of Pediatric Dentistry  
Mail to:  
CSPD (Dues Apply to the 2009 year)  
PO. Box 221608  
Carmel, CA 93922

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