

**CALIFORNIA SOCIETY OF PEDIATRIC DENTISTRY**  
**ASSOCIATE MEMBERSHIP APPLICATION**  
*(Non California Pediatric Dentist)*

\_\_\_\_/\_\_\_\_/\_\_\_\_  
 Date of Application

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		Dental School		Intern/Residency		Degree/Certificate
	From	To	From	To	From	To	

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

Dates		Place	Practice %	Teaching %	Research %
From	To				

CSPD requires membership in the American Academy of Pediatric Dentistry. This implies that you are an applicant, a student member or an active member of the American Dental Association. I satisfy the requirements of membership. \_\_\_\_ Yes / No \_\_\_\_

Make checks payable to:  
 California Society of Pediatric Dentistry  
 Mail to:  
 CSPD  
 P.O. Box 221608  
 Carmel, CA 93922

Application Fee: \$25  
 Annual Dues: \$155  
*dues will apply to the 2011 year - Total: \$180*