



Member Information

Name _____ Email Address _____
 Address _____ Daytime Phone (include area code) _____
 City _____ State, Zip _____ Evening Phone (include area code) _____
 Social Security Number _____ - _____ - _____
(optional)
 Dental hygiene school attended: _____ State: _____ Year of Graduation: _____

Highest educational level attained: Certificate Associate Baccalaureate Master's Doctorate
 Circle Your Credential: RDH LDH Other: _____ Current License #: _____ State: _____
 To qualify for Active membership, you must have been granted a license to practice. Applications received without a license number will not be processed.

Membership Demographic Information

In an effort to learn more about ADHA members, we would appreciate your assistance with the following information:
 Gender: Female Male Birth Date: _____ Ethnicity (optional): _____
 Hours worked per week in Dental Hygiene: _____
 Primary Position (check one): Clinician Educator Advocate Researcher Administrator/Manager Other
 State(s) in Which You Hold Current License(s): _____ License Number(s): _____ Year(s) Issued: _____

Annual Dues:

ADHA	\$ 170.00
NJDHA	\$ 50.00
Local component	\$ _____

01 Northern Component	\$10.00
02 South Jersey	\$10.00
03 Central DHA	\$12.00
04 Bergen DHA	\$10.00
05 South Shore DHA	\$ 7.00

Total \$ _____

Dues are not deductible as a charitable contribution for federal income tax purposes. They may be deducted as a business expense.

Method of Payment

I am enclosing a check payable to ADHA for the amount of my annual dues. (see Total)
 Please charge my annual dues to my credit card. (see Total) VISA MasterCard

Card Number _____ Expiration Date ____ / ____

Signature _____

DUES ARE NONREFUNDABLE

Send Application to

MAIL Division of Member Services
 444 North Michigan Avenue, Suite 3400, Chicago, IL 60611
PHONE (800) 243-2342
FAX (312) 467-1806
APPLY ONLINE at www.adha.org <<http://www.adha.org>>