HILLSBOROUGH COUNTY DENTAL ASSOCIATION

AN AFFILIATE OF THE WEST COAST DISTRICT, AMERICAN & FLORIDA DENTAL ASSOCIATIONS

The mission of the Hillsborough County Dental Association
is the advancement of the dental profession through education and fellowship.

HCDA Membership Application Protocol

1. Guest Meeting – Prospective members are welcome to attend a Hillsborough County Dental Association (HCDA) dinner meeting as our guest prior to becoming a member. Please call to RSVP so we can arrange for someone to serve as your host and allow you to see all that HCDA membership has to offer you. The HCDA office can be reached by phone at 813.447.3452 or by email at hcda@hcdafla.com.

   Application Process – When an application is completed, a dues payment of $245 for the year is required. If applying after the January meeting dues will be prorated for ½ year of membership to $97.50. The prorated dues will therefore be $147.50.

   Applicants must be a member in good standing with the Florida Dental Association (FDA) and the West Coast District Dental Association (WCDDA). If not a member of the FDA or WCDDA at time of application, you must join these associations within one year of application date. Active duty military and government employees are not required to join the FDA and WCDDA.

2. Membership Status – New members will be notified of the upcoming meetings and events, and will be able to attend the remaining HCDA functions for the membership year.

3. Membership Year/Dues – The HCDA membership year runs from September 1st through May 31st. Membership dues include five general membership meetings (including dinner), continuing education, and attendance at the annual holiday party for member and a guest.

   Members are kept abreast of the latest developments affecting dentistry through five HCDA newsletters and through the website. The HCDA central office is available to answer your questions and/or direct you to the proper resources.

Return to:
P.O. Box 202
Brandon, FL 33509
Questions? 813-447-3452
hcda@hcdafla.com

HILLSBOROUGH COUNTY
DENTAL ASSOCIATION
AN AFFILIATE OF THE WEST COAST DISTRICT,
AMERICAN & FLORIDA DENTAL ASSOCIATIONS

Membership Application

Name:_____ Email:_____

Office Address:_____ City:_____ Zip:_____

Office Phone Number:_____ Fax:_____

Home Address:_____ City:_____ Zip:_____

Cell/Home Phone Number:_____

Please send mail to: _____office address _____home address

Academic Training

Dental School:_____ Degree:_____ Year Graduated:_____

Post Graduate:_____

_____

Board Certification:_____

National and State Licenses

State Licenses (include year): _____

National Licenses or Boards (include year): _____

_____

Practice: _____Solo _____Associate

If associate, with whom:_____

Have you ever had patient complaints to any professional relations or peer review committee? ____Yes ____No

If Yes, give details:_____

Have you ever been investigated by the Department of Health of the Board of Dentistry?_____Yes ____No

If Yes, give details_____

Have you ever been convicted of a felony?_____Yes ____No

If Yes, give details_____

Have you ever been arrested for drug abuse?_____Yes ____No

If Yes, give details_____

Have you ever had an action taken against your license?_____Yes ____No

If Yes, give details_____

Have you ever been reprimanded for ethical misconduct?_____Yes ____No

If Yes, give details_____

Have you ever belonged to another dental association either in or out of state?_____Yes ____No

If Yes, give names, places and dates: _____

_____

I certify the above information to be true. Signed _____

I certify that I will abide by the constitution and bylaws and the code of ethics of the Hillsborough County Dental Association. Signed _____

I authorize the Hillsborough County Dental Association Membership Committee to seek information concerning the above questions for use in considering my candidacy for membership in the above said organization.
Signed _____

I certify that I am an ethical practitioner of dentistry and hereby apply for active membership of the Hillsborough County Dental Association. I authorize the release of any information to the Membership Committee of the Hillsborough County Dental Association for its use in considering this application.
Signed _____

Signed _____ Date _____

Do Not fill out information in shaded area.

Date application received on_____Amount received with application $_____
Date attended membership meeting_____
By action of the HCDA at meeting held on: Date:_____Secretary: _____

Please make checks payable to HCDA. We accept Visa/MasterCard/American Express/Discover.

Credit Card #_____Expiration Date: _____

Name it appears on card:_____Security Code: _____

Billing Address: _____

Signature: _____

Email to send receipt for payment: _____