

## MEMBERSHIP APPLICATION INSTRUCTIONS

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1. Answer every question completely. Explain items in detail on a separate sheet of paper if necessary. Applications with incomplete responses to instructions 1 to 4 will be returned for completion and may delay the application process. Please print clearly.
2. If you do not currently have a practice address, please provide your home address.
3. PLEASE ATTACH/SUBMIT THE FOLLOWING:
  - a. If appending a degree in addition to DDS or DMD, a legible and true copy of the diploma(s) or degree(s) conferred upon you (which must be authenticated by either the president, secretary, dean or registrar of the educational institution attended and accompanied by a certified original translation by a qualified translator if written in a foreign language);
  - b. Specialty Certificate;
  - c. If you qualify as a full-time faculty member, please provide a verification letter from the school;
  - d. If you are currently enrolled in a residency or graduate program, provide a verification of program enrollment.
4. Upon receipt of your application, you will be contacted regarding payment of dues.
5. Our goal is to process your application as quickly as possible. If you have not heard from us in 30 days, please contact your component dental society.
6. Please return completed application to your component dental society.  
To find your component dental society please call: 800.CDA.SMILE or search online at, [cda.org](http://cda.org).

Contra Costa Dental Society  
3406 Hall Lane  
Lafayette, CA 94549-3903  
925.284.8662 phone  
925-284-8661 fax  
[execdirector@ccdds.org](mailto:execdirector@ccdds.org)

# CONTRA COSTA DENTAL SOCIETY MEMBERSHIP APPLICATION

(PLEASE PRINT CLEARLY)

1. APPLICATION TYPE:  Initial application  Re-application  Indefinite practice address

2. PERSONAL INFORMATION Gender:  Male  Female

Name: \_\_\_\_\_ ADA No.: \_\_\_\_\_  
FIRST MIDDLE LAST

Have you ever been known by any other name(s)?  Yes  No SSN (optional): \_\_\_\_\_

If yes, please provide name(s): \_\_\_\_\_ Date of birth: \_\_\_\_\_

Year of first licensure in the U.S.: \_\_\_\_\_ Where?: \_\_\_\_\_

California Dental Lic. No.: \_\_\_\_\_ Year licensed: \_\_\_\_\_

**PRIMARY OFFICE ADDRESS**

Street: \_\_\_\_\_ Office phone: \_\_\_\_\_ Fax: \_\_\_\_\_

City: \_\_\_\_\_ State/ZIP: \_\_\_\_\_ Pager: \_\_\_\_\_

E-mail: \_\_\_\_\_

Do you practice at any additional offices?  Yes  No

**Mailing Address:** *(To be used for all correspondence and for publication in membership directory)*  
 Primary office address  Home address

**SECOND OFFICE**

Street: \_\_\_\_\_ Office phone: \_\_\_\_\_ Fax: \_\_\_\_\_

City: \_\_\_\_\_ State/ZIP: \_\_\_\_\_ E-mail: \_\_\_\_\_

**HOME**

Street: \_\_\_\_\_ Phone: \_\_\_\_\_ Spouse name: \_\_\_\_\_

City: \_\_\_\_\_ Fax: \_\_\_\_\_ Is Spouse a dentist?  Yes  No

State/ZIP: \_\_\_\_\_ E-mail: \_\_\_\_\_

Were you referred by a current member? If yes, by whom? \_\_\_\_\_

3. PRACTICE INFORMATION

PRIMARY OFFICE

SECOND OFFICE

a. Name of practice: \_\_\_\_\_

b. Type of practice: \_\_\_\_\_

c. Nature of employment: \_\_\_\_\_  
(i.e. owner, associate, employee, independent contractor)

d. Owner of the practice/records: \_\_\_\_\_

4. EDUCATION

SCHOOL

STATE/COUNTRY

DATE

DEGREE EARNED/SPECIALTY

Dental school: \_\_\_\_\_ to \_\_\_\_\_

Internship: \_\_\_\_\_ to \_\_\_\_\_

Postgraduate: \_\_\_\_\_ to \_\_\_\_\_

5. BENEFITS

Do you have or plan to apply for TDIC professional liability coverage?  Yes  No

Do you plan to attend the next CDA Presents meeting? **Anaheim**  Yes  No **San Francisco**  Yes  No

**FOR COMPONENT USE ONLY**

Date Application Submitted to Local Society: \_\_\_\_\_

Date Application Submitted to CDA: \_\_\_\_\_

Date Application Returned From CDA: \_\_\_\_\_

**FOR CDA OFFICE USE ONLY**

Status: \_\_\_\_\_

Quote for membership year: \_\_\_\_\_

ADA dues: \$ \_\_\_\_\_ CDA dues: \$ \_\_\_\_\_

Can Prorate ADA:  Yes  No Can prorate CDA:  Yes  No

Date quote requested from ADA: \_\_\_\_\_

Date quote sent to Component: \_\_\_\_\_

Date elected: \_\_\_\_\_

# CONTRA COSTA DENTAL SOCIETY MEMBERSHIP APPLICATION

## 6. PRACTICE INFORMATION

- I am a general dentist
- I am a specialist in the ADA recognized specialty of \_\_\_\_\_  
*(Please submit a copy of specialty certificate)*

## 7. PERMITS

Do you or your employer practice under a name other than that which appears on your license?  Yes  No

If yes, please provide name(s) \_\_\_\_\_

*If yes and you have not already done so, you are required to obtain a fictitious name permit from the **Dental Board of California**:*

Telephone: 916.263.2300, Ext. 2332      Web site: [dbc.ca.gov](http://dbc.ca.gov)

Is conscious sedation administered in your office?  Yes  No

Permit holder's name: \_\_\_\_\_

Is general anesthesia administered in your office?  Yes  No

Permit holder's name: \_\_\_\_\_

Do you write Schedule II prescriptions?  Yes  No

If yes, provide your narcotics license number: \_\_\_\_\_

## 8. MEMBERSHIP AND LICENSURE DISCIPLINARY ACTION

A) Have you ever received notice that you failed to comply with or been subject to the adverse decision of a duly constituted committee of a constituent or component dental society of the American Dental Association, or is any such action pending?  Yes  No

B) Are you currently subject to any state board disciplinary action resulting from an adverse decision (suspension, probation terms, etc.) regarding your California dental license?  Yes  No

If the answer to any of the foregoing questions is "yes," please provide full details (please attach an additional piece of paper, if necessary).

\_\_\_\_\_  
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\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

# MEMBERSHIP ACKNOWLEDGEMENTS AND AGREEMENTS

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## A. BYLAWS AND CODES COMPLIANCE AGREEMENT

I hereby agree to abide by the CDA Code of Ethics, the ADA Principles of Ethics and Code of Professional Conduct and the bylaws of the component dental society, the California Dental Association and American Dental Association.

I hereby acknowledge and agree, as to any patient I treat, to comply with the reasonable requests of a duly constituted peer review committee as set forth in Section 3 of the CDA Code of Ethics and to abide by the decisions of such body. It is understood that this may require, among other things, that I provide patient records, including x-rays, study models, or other documents necessary in order for a committee to conduct a peer review. In the event of a peer review decision in favor of the patient, funds will be made available by me as designated by the peer review decision. I also acknowledge that non-compliance with a duly constituted peer review committee, a single peer review case involving grossly inadequate or grossly inappropriate treatment, and/or a pattern of negligent or inappropriate practice (i.e., three or more adverse peer review decisions in a 24-month period), may result in the referral to the Judicial Council for investigation of possible ethical violations.

An adverse Judicial Council decision could result in a report to the Dental Board of California and the National Practitioner Data Bank, as mandated by law. In addition, such matters and violations of the CDA Code of Ethics may result in the imposition of discipline by CDA, including censure, suspension, or expulsion.

All ADA documents may be obtained at [ada.org](http://ada.org), all CDA documents at [cda.org](http://cda.org) and component documents may be available from a component dental society office or Web site.

## B. MEMBERSHIP AGREEMENT

I CERTIFY THAT all statements made by me in this application are complete, true and correct. I agree that if any such statements are found to be false, or if there are material omissions made, this application may be rejected solely on those grounds, or in the event such false statement or omission does not become known to the dental society until after I have been elected, that I may be removed immediately from membership on the basis of the false statement of omission alone. For the purposes of this paragraph, I understand that a material misstatement or omission shall mean one which is "not insubstantial" or one which is "significant in relation to the questions asked." Upon becoming a member, I hereby waive the right to hold component dental society, CDA, ADA, or any member thereof, responsible for any damage in case of disciplinary action involving me, after a hearing in accordance with the bylaws of these organizations.

## C. FAX AND EMAIL CONSENT

I understand that by providing the fax number(s) and email address(es) in Section 2 of this application, I hereby consent, on behalf of myself and on behalf of any entity specified in Section 7 of this application, to receive faxes and emails sent by or on behalf of the component dental society, CDA, ADA, The Dentists Insurance Company, TDIC Insurance Solutions, and California Dental Association Foundation. If I am giving this consent on behalf of an entity specified in Section 7 of this application, I hereby represent and warrant that I am duly authorized to execute and deliver this consent on behalf of that entity.

\_\_\_\_\_  
*Name of applicant (please print)*

\_\_\_\_\_  
*Signature*

\_\_\_\_\_  
*Date*

## FOR COMPONENT STAFF USE ONLY

Applicant Name: \_\_\_\_\_

### Application review checklist

### Component

- |   |                              |                             |
|---|------------------------------|-----------------------------|
| Are all questions on the application answered and application signed? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Did applicant provide his/her dental license number?                  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Does applicant append additional degrees after his/her name?          | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| If Yes, did applicant include proper documentation?                   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

### Currently:

- |   |                              |                             |
|---|------------------------------|-----------------------------|
| Has the applicant been denied membership in a component dental society?   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Has the applicant been expelled or suspended for ethical reasons?   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Is the applicant's license currently subject to disciplinary action by the Dental Board (i.e., probation, suspension, etc.) ? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Is the applicant being considered for "Conditional" membership status or denial?  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Does the applicant have any unresolved Peer Review cases?   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| (For transfer applicants - See Transfer Applicant Guidelines)   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

If Yes to any items in this box, mandatory referral to MARS is necessary.  
Please complete the "Component Referral To MARS" form and forward the application to MARS for review.

Forwarded to MARS

### HELPFUL ITEMS:

#### DENTAL BOARD OF CALIFORNIA INFORMATION:

**Telephone:** 916.263.2300

**Web site:** dbc.ca.gov

(Once on web site, if you use the "License Verification" option, you will be able to check current license status, permits, disciplinary actions and business ownership all on the same web page)

#### DEPARTMENT OF MANAGED HEALTH CARE

**Telephone:** 800.HMO.2219

**Web site:** dmhc.ca.gov