



Signature

Application for Membership

Please complete this application form legibly in all respects, using capital letters.

Type of Membership	1. Annual <input type="checkbox"/> 2. Life <input type="checkbox"/> 3. Direct <input type="checkbox"/> 4. Affiliate <input type="checkbox"/>
General Information	Title <input type="text"/> Last Name <input type="text"/> First Name <input type="text"/> Middle Name <input type="text"/> Preferred Name (for mailing) <input type="text"/>
Personal Information	MM <input type="text"/> DD <input type="text"/> YY <input type="text"/> Sex M <input type="checkbox"/> F <input type="checkbox"/> Marital Status M <input type="checkbox"/> S <input type="checkbox"/> Blood Group <input type="text"/> Name of Spouse <input type="text"/> Is your Spouse a Dentist Y <input type="checkbox"/> N <input type="checkbox"/> Number of Children <input type="text"/> Is your Spouse a Member of IDA Y <input type="checkbox"/> N <input type="checkbox"/>
Edu. Qualification	Graduation / University <input type="text"/> Institute <input type="text"/> Yr. of Passing <input type="text"/> Post Graduation / University <input type="text"/> <input type="text"/> Yr. of Passing <input type="text"/> Specialisation <input type="text"/> Regd. No. <input type="text"/> State <input type="text"/>
Practice Information	Type of Practice: General Practice <input type="checkbox"/> Endodontics <input type="checkbox"/> Periodontics <input type="checkbox"/> Orthodontics <input type="checkbox"/> Pediatric Dentistry <input type="checkbox"/> Prosthodontics <input type="checkbox"/> Oral & Maxillofacial Surgery <input type="checkbox"/>
Affiliation	Institute / Hospital <input type="text"/>
Designation	Lecturer <input type="checkbox"/> Asso. Professor <input type="checkbox"/> Professor <input type="checkbox"/> Dean <input type="checkbox"/> Director <input type="checkbox"/> Oral Pathologist <input type="checkbox"/> Prosthodontist <input type="checkbox"/> Pedodontist <input type="checkbox"/> Periodontist <input type="checkbox"/> Orthodontist <input type="checkbox"/> Dental Surgeon <input type="checkbox"/> Others <input type="checkbox"/>
Mailing Address	(Please indicate preference of mailing address) 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/>
1. Office Address	Practice Name <input type="text"/> Address <input type="text"/> Address <input type="text"/> Area <input type="text"/> City <input type="text"/> Dist. <input type="text"/> Taluka <input type="text"/> Pin Code <input type="text"/> State <input type="text"/> Tel. No. 1 <input type="text"/> Tel. No. 2 <input type="text"/> Fax No. <input type="text"/> Cell Number <input type="text"/> Office Timing <input type="text"/> Email Address 1 <input type="text"/> 2 <input type="text"/>

2. Office Address

Practice Name Address

Address

Area City Dist. Taluka Pin Code

State Tel. No. 1 Tel. No. 2

Fax No. Office Timing

3. Home Address

Address

Address

Area City Dist. Taluka Pin Code

State Tel. No. 1 Tel. No. 2

Subscription

Subscription:

A) Annual Member: Admission fee (New) Rs. 300/-
Annual /Renewal fee - Rs.650/-

B) Life Member: - Admission fee (New) - Rs.300/-
Life Membership fee (one time) Rs.10, 650/-

C) Affiliate member annual fee - US \$100 (Payable only at IDA HO)

Cheque / DD Number Date / Month Year Bank

Credit Card No.

- * Enrolment / Renewals can be made either at IDA HO / State / Local Branches.
- * Outstation Payment to be made by DD / Credit Card Only.

Declaration

I declare that I have read through the details of the IDA Application Form, the Constitution, Bye-Laws, Code of Ethics & professional conduct and resolve to abide by them. I am not a member of any association functioning parallel to IDA in my area & have not been convicted by any court of law. (This does not include specialty societies). I am not engaged in any activity detrimental to the interest of any association. The information provided by me is true & I hereby submit my application for membership to IDA.

(New members must attach supporting documents.)

Signature _____ Date: _____

Office Use Only

IDA HO Address	State Branch Address	Local Branch Address
<p>Indian Dental Association Bombay Mutual Terrace, 2nd Flr. 534, Sandhurst Bridge, Opera House, Mumbai-400 007</p> <p>Tel. : 022 2367 1515 022 2369 6655</p> <p>Fax : 022 2368 5613</p> <p>Email : ho@ida.org.in</p>		
<input type="text"/>	<input type="text"/>	<input type="text"/>
Date & Signature	Date & Signature	Date & Signature

Remarks