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

P.O. BOX 1833 • Brandon, FL 33509 • 941-677-8194

DATE _____

NAME _____ FL LIC. # _____

OFFICE ADDRESS _____

PHONE # _____ FAX # _____

Date of Birth _____ E-Mail _____

Initial Date of Practice in Manatee County _____

Practice Is Solo _____ Associate _____ Contract _____

Undergraduate School _____ Year _____

Dental School _____ Year _____

Degree Obtained _____

Postgraduate Training _____

_____

Date of FL Board _____

National Licenses or Boards (Include Year) _____

Specialty Information: Please include any information that would be helpful in making referrals._____

_____

CHRONOLOGICAL HISTORY OF PRACTICE SINCE GRADUATION

1. _____
2. _____

3. _____

4. _____

SPOUSES'S NAME _____

HOME ADDRESS _____

PHONE # _____

Have you ever been investigated by the Board of Dentistry? _____ the Department of Regulation? _____ If **Yes**, give details: _____
_____

Have you ever been convicted of a felony? _____ If **Yes**, give details: _____
_____

Have you ever been convicted for drug abuse? _____ If **Yes**, give details: _____
_____

Have you ever had your license suspended? _____ If **Yes**, give details: _____
_____

Have you ever been reprimanded for ethical misconduct? _____ If **Yes**, give details: _____
_____

Have you ever belonged to another Dental Association either in or out of the state? _____
If **Yes**, please give names, places and dates: _____
_____
_____

I certify the above information to be true.

_____
Applicant's Signature

I certify that I will abide by the Articles of Incorporation and the By-laws of the Manatee Dental Society. I authorize the Membership Committee to seek information concerning the above questions for use in considering my candidacy for membership into the Manatee Dental Society.
I certify that I am an ethical practitioner of dentistry and hereby apply for membership in the Manatee Dental Society.

_____ _____
Date Applicant's Signature

MANATEE
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AN AFFILIATE OF THE WEST COAST DISTRICT,
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Payment Form

Name(s):
_____

Payment Method: Credit Card ☐ Check: ☐ Made payable to MDS

Credit Card No: _____ Exp. Date: _____ CVV: _____

Billing Address: _____

City: _____ State: _____ Billing Zip Code: _____

Signature: _____

Total $ _____

Remit payment form or mail check to: MDS
Email: info@manateedentalsociety.org * Fax: (813) 654-2505
P.O. Box 1833, Brandon, FL 33509

Member Dues are $375