



CADA
135-11 40th Road Suite 4D
Flushing, NY 11354
CADANY.org

Thank you for your interest in becoming a member of CADA.

Please complete all sections of this application. Print or type all information.

For Official Use Only

Personal Information

Name (First)		(Last)	(Middle)	<input type="checkbox"/> Male <input type="checkbox"/> Female
CADA ID Number (will be assigned)		Date of Birth (MM/DD/YYYY)	Website Address	
Primary Office Address				Suite
City	State	Zip	Office Phone (include area code)	
Email Address			Fax (include area code)	
Home Address			Cell Phone (include area code)	
City	State	Zip	Home Phone (include area code)	

Biographical Information

Dental School	Country	Graduation Date (MM/DD/YYYY)
Advanced Education Program (if applicable)	Completion Date (MM/DD/YYYY)	Certificate/ Degree
Please indicate if licensed: <input type="checkbox"/> Presently <input type="checkbox"/> License pending If licensed, please list license number(s), date, year and state(s). Please indicate specialty license information if applicable.		
Are you board certified in an ADA recognized specialty? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, which specialty? <input type="checkbox"/> Endodontics <input type="checkbox"/> Pediatric Dentistry <input type="checkbox"/> Periodontics <input type="checkbox"/> Prosthodontics <input type="checkbox"/> Orthodontics <input type="checkbox"/> Oral & Maxillofacial Surgery		
Is your practice limited to one of the above specialties? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, which specialty?		
Please indicate if practicing in, or looking for: <input type="checkbox"/> Solo <input type="checkbox"/> Group <input type="checkbox"/> Partnership <input type="checkbox"/> Associateship <input type="checkbox"/> Clinic <input type="checkbox"/> Faculty <input type="checkbox"/> Federal Dental Service <input type="checkbox"/> Other:		

If practicing in other than a solo practice, please indicate the group or practitioner's name and location.

Name		
Street		
City	State	Zip



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Personal Background

Have you ever been denied a dental license? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, in which state:	If yes, why?
Have you ever had your license suspended or revoked? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, in which state:	If yes, why?
Have you ever been censured, suspended or expelled by a dentally related organization (i.e. dental society)? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, in which state:	If yes, why?
Have you ever been convicted of a felony or criminal offense, including driving under the influence of alcohol or drugs, but excluding minor traffic violations and parking tickets? (A conviction record will not automatically bar you from membership. Each application will be individually considered on its merits.) <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please describe (include dates, offenses and penalties):	

Applicant Signature

I hereby apply for membership in the Chinese American Dental Association and resolve to abide by the <i>Bylaws</i> of CADA if accepted into membership. Review the bylaws at CADANY.org.	
Signature	Date (MM/DD/YYYY)

Dues Section

<input type="checkbox"/> CADA Membership \$ 400.00 (includes two study clubs per year)

Application Endorsement (CADA membership application must be endorsed by an officer of the CADA committee*)

Name of CADA Committee Member endorsing application

*If you do not know anyone in the committee, please attend our upcoming study club to meet our fellow members.

Please submit your payment and completed 3-page application to:

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All applications received will be reviewed by the CADA membership committee during the quarterly Board meetings.
 After the application is reviewed, a letter will be sent out to applicants indicating application status.
 CADA does not guarantee membership to other organizations.

To Be Completed By CADA:

Committee Member	Name	Signature	Date	<input type="checkbox"/> Approved <input type="checkbox"/> Disapproved
Committee Member	Name	Signature	Date	<input type="checkbox"/> Approved <input type="checkbox"/> Disapproved
Dues Received <input type="checkbox"/> CADA		Date Received	Notes	

CADA Membership Application Check List

Name of Applicant

- ☐ Copy of your Dental Degree
- ☐ Copy of your Dental License
- ☐ Copy of your Board Certificate (if applicable)
- ☐ Copy of your Certificate(s) of Professional Malpractice/ Liability Insurance coverage (declarations page)
- ☐ Copy of your current Curriculum Vitae (most updated in month/ year format)
- ☐ Application endorsed by a CADA Committee Member
- ☐ Check in the amount of \$400, payable to "CADA"
- ☐ Photo of Applicant in .JPEG format emailed to cadany.org@gmail.com

To maintain an active membership, it is mandatory that all members must attend **at least two study clubs per year**.

All study club information can be found on the website at www.CADANY.org.

I acknowledge that I have read and understand the CADA membership requirements.

Signature

Date