



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 <small>(will be assigned)</small>		Date of Birth <small>(MM/DD/YYYY)</small>		Website Address
Primary Office Address				Suite
City		State	Zip	Office Phone <small>(include area code)</small>
Email Address				Fax <small>(include area code)</small>
Home Address				Cell Phone <small>(include area code)</small>
City		State	Zip	Home Phone <small>(include area code)</small>

Biographical Information

Dental School		Country	Graduation Date <small>(MM/DD/YYYY)</small>
Advanced Education Program <small>(if applicable)</small>		Completion Date <small>(MM/DD/YYYY)</small>	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? <small>(A conviction record will not automatically bar you from membership. Each application will be individually considered on its merits.)</small> <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 \$ 250

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		Date Received	Notes	
<input type="checkbox"/> CADA				

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 \$250, payable to "CADA"**

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