



IADA Membership/Update Form 2007-2008

First Name:

Middle Initial:

Last Name:

MAILING ADDRESS:

Street: _____ City: _____ State: _____ Zip: _____

Best Contact Phone: _____ EMAIL: _____

Office Number: _____ Fax Number: _____

EDUCATION:

First Degree: _____ Year Graduated: _____ School: _____

Second Degree: _____ Year Graduated: _____ School: _____

SPECIALTY: _____ Year Graduated: _____ School: _____

OFFICE INFORMATION:

Address: _____ - _____

Type of Practice: _____

Phone #: _____ Web Site: _____

PRIVACY:

I do not wish to have my name and information published on IADA's website or other publications

Dentist Membership Dues (Please choose from one of the 2 options):

One full payment of \$480.00

Each meeting for current students and residents \$35.00

Each meeting for allied professionals (RDH, RDA, CDT) \$50.00

Each meeting for 1st year graduates \$50.00

Single session for Non members with dinner \$85.00

PAYMENT METHODS:

Check Cash Credit Card # _____ Exp. _____

Billing Zip Code: _____

I hereby authorize IADA to debit my credit card in the amount of: \$ _____

Signature _____ Date: _____

IRANIAN AMERICAN DENTAL ASSOCIATION, PO BOX 948, SANTA MONICA, CA 90406

PHONE: (310) 899 – 6010, FAX: (310) 899 – 6028, WEBSITE: WWW.IRADA.ORG