

# AMERICAN DENTAL HYGIENISTS' ASSOCIATION

*Professionals promoting total health through quality oral health care.*

## Membership Application

Division of Member Services  
444 N. Michigan Ave., Suite 3400, Chicago, IL 60611  
800-243-2342 • 312-440-8900 • FAX 312-467-1806 • www.adha.org

\_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_  
Social Security Number

\_\_\_\_\_  
Name (Last, First, Middle Initial)

Circle Your Credential:  
RDH LDH Other:\_\_\_\_\_

\_\_\_\_\_  
Maiden Name (If applicable)

\_\_\_\_\_  
Email Address

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
Daytime Telephone (include area code)

\_\_\_\_\_  
City/State/Zip Code

\_\_\_\_\_  
Evening Telephone (include area code)

Dental hygiene school attended : \_\_\_\_\_ State: \_\_\_\_\_ Year of Graduation: \_\_\_\_\_

**To qualify for Active membership, you must have been granted a license to practice dental hygiene.**

Current License #: \_\_\_\_\_ State: \_\_\_\_\_

(Required)  
Highest educational level attained  Certificate  Associate  Baccalaureate  Master's  
 Doctorate

### Annual Dues:

National Dues \$ 155.00

Constituent Dues\* \$ \_\_\_\_\_  
(state)

Component Dues\* \$ \_\_\_\_\_  
(local)

Assessment\* \$ \_\_\_\_\_  
(if applicable)

**\*Call 800/243-2342,  
press #1 for correct  
dues amount.**

\$6.00 and \$5.00 of the annual ADHA membership dues are allocated for subscriptions to the *Journal of Dental Hygiene* and *Access*, respectively. Dues are not deductible as charitable contributions for federal income tax purposes. They may be deducted as a business expense.

**TOTAL** \$ \_\_\_\_\_

### Method of Payment: (See back of form for Payment Plan options)

I am enclosing a check payable to ADHA for the amount of my annual dues as determined above.

Please charge my annual dues as determined above to my credit card.  
(Complete the credit card information below.)  VISA  MasterCard

Card Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Expiration date: \_\_\_\_\_

Name as it appears on the card:(Please print) \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**DUES ARE NONREFUNDABLE**

## PAYMENT PLAN OPTIONS

- I want to enroll in the ADHA EASY 4 Payment Plan through my credit card.** I agree to pay one full year's dues of \_\_\_\_\_ (enter amount from the "Total" line on the reverse side of this form) which will include constituent and component dues (component where applicable). I understand that my dues will be billed quarterly (4 times) through my VISA or MasterCard and that a \$10.00 annual ADHA service charge will be included in the first quarterly payment.

VISA       MasterCard

Card Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_      Expiration date: \_\_\_\_\_

Name as it appears on the card: (Please print) \_\_\_\_\_

Signature: \_\_\_\_\_      Date: \_\_\_\_\_

- I want to use the ADHA EASY 4 Payment Plan through my checking account.** I am enclosing 1/4 of my total dues plus a one-time annual ADHA service charge of \$10.00 now. I hereby authorize the American Dental Hygienists' Association to initiate debit entries to my checking account indicated below and authorize the financial institution named below to debit the same to such account.

Financial institution: \_\_\_\_\_

Branch (where applicable): \_\_\_\_\_

City/State: \_\_\_\_\_

*This authority will remain in effect until 3/4 of one year's membership dues has been debited to my checking account. I understand a payment will be debited 3 times approximately every three months (depending on the date of receipt of my initial payment and service charge) for 1/4 of my annual dues.*

Signature: \_\_\_\_\_      Date: \_\_\_\_\_

To accommodate the needs of members, ADHA offers two dues billing cycles: summer and winter. The summer dues billing cycle begins April 1 and ends September 30. The winter cycle begins October 1 and ends March 31. All new members will be assigned to one of the two dues billing cycles depending on the time of year that the application is submitted.

If you know another dental hygienist who would benefit from membership, simply complete the section below. An application and member benefits information will be mailed immediately.

\_\_\_\_\_  
Name

\_\_\_\_\_  
Phone

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
Email Address

\_\_\_\_\_  
City/State/Zip Code