



SOCIETY OF AMERICAN INDIAN DENTISTS

P.O. Box 15107 • Phoenix, Arizona 85060 • (602) 954-5160

MEMBERSHIP APPLICATION

MEMBERSHIP CATEGORY (Check one and submit supporting documents as required)

FULL — \$50.00

1. Copy of Dental Degree
2. Certificate of Indian Blood Degree or Enrollment Verification
3. Yearly membership dues

STUDENT — \$10.00

1. Certificate of Indian Blood Degree or Enrollment Verification
2. Yearly membership dues

ANCILLARY — \$25.00

1. Yearly membership dues

FULL NAME _____

HOME ADDRESS: _____ BUSINESS ADDRESS: _____

PHONE _____ PHONE _____

TRIBAL AFFILIATION _____

SPOUSE'S NAME _____ CHILDREN _____

List w/Ages _____

PRESENT POSITION _____ SPECIALTY _____

TYPE OF PRACTICE Private Public Health Academic

Other _____

specify

UNDERGRADUATE EDUCATION

Institution _____

Year(s) _____ Degree _____ Major _____

POSTGRADUATE EDUCATION

Institution _____

Year(s) _____ Degree _____ Major _____

Institution _____

Year(s) _____ Degree _____ Major _____

HONORS AND AWARDS _____

ACTIVITIES _____

SPECIAL INTERESTS (e.g. Hobbies) _____

Signature _____ Date _____

**Please return this Membership Application, along with supporting documents and annual membership dues to:
SAID, P.O. Box 15107, Phoenix, AZ 85060 (Membership effective January 1 - December 31 in current year.)**