



New York County Dental Society
6 East 43rd Street - 11th Floor
New York, New York 10017
212-573-8500 Fax: 212-573-9501
www.nycdentalsociety.org

APPLICATION FOR MEMBERSHIP REINSTATEMENT

Please note that all reinstatement applications are subject to a \$25 administrative fee in addition to the dues quoted in the accompanying cover letter.

Name: _____ Gender M F

ADA#: _____ License #: _____

Office Address: _____

Telephone: _____ Fax: _____

Email: _____ Date of Birth _____

Home Address: _____

Telephone: _____ Fax: _____

Email: _____

To which address would you prefer to have your mail sent? Home Office

Which address would you prefer to have as your directory listing? Home Office

Indicate Specialty Designation: (please circle one)

Endodontist
Pedodontist

General Practitioner
Periodontist
Oral and Maxillofacial Radiology

Orthodontist
Prosthodontist

Oral Surgeon
Public health

If my membership is reinstated, I agree to comply with all By-laws, Code of Ethics, Rules and Regulations of the New York County Dental Society.

Date: _____ Signature: _____