



INTERNATIONAL DENTAL IMPLANT ASSOCIATION MEMBERSHIP APPLICATION

NAME *(As you wish it to appear on membership certificate)*

First _____ Initial(s) _____ Last _____

Degree(s) _____, _____, _____

Delivery of Certificate By Mail At the Annual Meeting At an Implant Seminars Course

ADDRESS

Practice/Business Name _____

Address _____ Suite _____

City _____ State _____ Zip _____

Office Telephone _____ Office Fax _____

Cell Phone _____ E-Mail Address(s) _____

Web Site _____

Best Time to Contact: _____

EDUCATION AND TRAINING

Undergraduate School _____ Degree(s) _____ Year _____

Dental School _____ Degree(s) _____ Year _____

Specialty or Post-Graduate Studies _____

_____ Degree(s) _____ Year _____

CONTINUING EDUCATION AND TRAINING

Course Name _____ CE Hours _____ Year _____

Course Name _____ CE Hours _____ Year _____

Course Name _____ CE Hours _____ Year _____

IMPLANT DENTISTRY EXPERIENCE

Implant Continuing Education Hours in last 3 Years _____

Experience in Implant Dentistry: less than 10 cases 10-49 cases 50-100 cases more than 100 cases



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ANNUAL MEMBERSHIP (DUES - \$350 per year) BENEFITS

- ✓ A beautiful membership certificate with hand calligraphy
- ✓ Use of the International Dental Implant Association logo on your stationary, website and business cards
- ✓ Opportunity to achieve advanced credentials (Fellowship, Mastership and Diplomate) and receive a beautiful presented credentialed certificate at one of our sponsored meetings
- ✓ Member exclusive discounts with numerous vendors
- ✓ Receive weekly emails on practice growth
- ✓ Access to our website to view and download patient forms and marketing materials

PAYMENT INFORMATION

Return this application with your membership dues to:

The International Dental Implant Association
17501 Biscayne Blvd.
Suite 600
North Miami Beach, FL 33160
305.945.7334

Checks: Please make payable to The International Dental Implant Association and send to the above address.

Or fax: 1.305.397.2830

Or email: admin@internationaldentalimplantassociation.com

Credit Cards: Please complete the following information

MasterCard Visa American Express Discover

Name on Card _____

Card # _____

Exp. Date _____ CVV# _____

Billing Zip Code _____

Signature _____ Date _____

**** MEMBERSHIP WILL BE RENEWED EVERY 12 MONTHS FROM THE DATE OF JOINING AND
AUTOMATICALLY BILLED TO THE CREDIT CARD PROVIDED ****