

# ADA SA Branch

# DENTIST

# Membership Application



Personal Details			
First Name:		Preferred Name:	
Middle Names:		Last Name:	
Title: (e.g. Mr Dr Prof)		Suffix: (e.g. AO AM AC OAM)	
Gender:		Date of Birth:	
Home Phone:		Preferred Work Phone:	
Mobile:		Preferred Fax:	
Email:		Website:	
Partner's Name:		Languages Spoken:	

Personal Address Information	
Home Address:	
Preferred Mailing Address:	
Preferred Billing Address	

Personal Qualification Information			
Initial Qualification:		Graduating University:	
Year of Qualification:		Year of Graduation:	
Additional Qualifications:	Conferring University/Body:	Year of Qualification:	
ADA Awards Received:			

## Membership/Registration Information

Which ADASA Branch Category are you applying for: (please use subscription rates)			
PI Provider e.g. Guild		Which PI Category are you applying for: (please use subscription rates)	
PI Client No: (If transferring membership)		PI Policy N <sup>o</sup> : (If transferring membership)	
Which Federal ADA Category are you applying for: (please use subscription rates)	Federal ADA N <sup>o</sup> : (If transferring membership)	Federal ADA Join Date: (If transferring membership)	
Dental Board Registration N <sup>o</sup> :		Which Dental Board Register Listings are you on:	

## Other Information

Membership Honourship Organisations e.g. PFA, FADI:			
Membership Affiliate Societies e.g. DASI, ASE, ASP:			
Are you currently practicing:	YES / NO	If not, why not (please identify):	
Retired / Overseas / Maternity / Parenting Leave / Student / Postgraduate / Unemployed / Lecturing / Administration / Leave of Absence (please specify date of return) .....			
Employment Status (please identify):		Full Time / Part Time / Casual / Contracted	
Average Weekly Hours Worked (please identify):		16 hours or less / 16 – 24 hrs / 24 hours or more	
Do you employ staff:	YES / NO	How many years before you intend to leave the dentistry workforce?	
Do you wish to be included on the ADASA Emergency Roster?	YES / NO	If yes please provide emergency contact number:	
Do you perform General Anaesthetics:	YES / NO	With which hospitals are you accredited to perform GA's:	
Do you have any personal areas of special interest e.g. Hypnotherapy, Sedation, TMJ, Sleep Apnoea:			
University Tutor:	YES / NO	University Lecturer:	YES / NO
		University Mentor:	YES / NO
TAFE SA Tutor:	YES / NO	TAFE SA Lecturer:	YES / NO
Are you contracted to a Health Fund	YES / NO	If yes Please specify:	

## PRINCIPAL PRACTICE

Practice Name:							
Practice Address:							
Practice Phone:				Practice Fax:			
Practice Email:				Practice Website:			
Practice Type (please identify):		Private / SA Dental Service / Health Fund / Armed Forces / University / Other.....					
Employment Type (please identify):		Sole Owner / Partner / Associate / Government / Casual / Contracted / Employee / Locum / Other .....					
Practice Owner's Name:		Principle Dentist's Name:		Practice Manager's Name:			
Practice Focus if any (e.g. Orthodontics, Aged Care)				Practice Restricted Focus to (e.g. Paediatrics, Aged, Endodontics):			
Practice Hours Week Days		Practice Hours Evenings		Practice Hours Weekend			
Does your practice have Wheelchair Access:		YES / NO					
Does your practice participate in the following dental schemes (please tick):							
SADS General Dental Scheme (GDS)				SADS School Leaver Postcard			
						Medicare 'Cleft Lip' Scheme	
SADS Emergency Dental Scheme (EDS)				SADS Lift the Lip			
						DVA	
SADS Pensioner Dental Scheme (PDS)				'Give a Smile' Scheme			
						Workcover	
Does your practice provide the following services (please tick):							
Nursing Home Care				Palliative Care			
						Supported Residential Facilities	
No. Of Chairs in Practice				Within current practice hrs how many extra patients could you treat/week			
Do you wish this practice to be busier than at present				YES /NO		If yes, No. Of dentist hrs/week	
Does your practice utilise Service Trust		YES / NO		Does your practice have Pty Ltd Co attached			YES / NO
No. Of dentist working at practice		No. Of DA's/Nurses working at practice		No. Of hygienists working at practice		No. Of therapists working at practice	
Total hours of dentists working at practice		Total hours of DA's/Nurses working at practice		Total hours of hygienists working at practice		Total hours of therapists working at practice	
No. Of technicians working at practice		No. Of prosthetists working at practice		No. Of office staff working at practice		No. Of Therapists working at practice	
Total hours of technicians working at practice		Total hours of prosthetists working at practice		Total hours of office staff working at practice		Total hours of Therapists working at practice	
Do any specialist visit this practice		YES / NO		Name of specialist			
Specialist area				Average hours worked/month			

## Declaration

I ..... hereby apply for membership for the Australian dental Association, South Australian Branch Incorporated. I agree to be bound by the constitution and Code of Ethics for the time being in force. These documents are available on the ADASA website or will be provided to you on request from ADASA on 08 8272 8111.

I undertake at all times to uphold the professional and ethical obligations of membership.

I understand that application of membership also includes mandatory membership to the Australian Dental Association Inc. (Federal) by virtue of requirements under the Constitution of the Australian Dental Association SA Branch Inc.

I further understand that I must notify the Australian Dental Association SA Branch Inc. in writing of any change of status (e.g. changing number of declared hours worked).

Have you currently or in the past had a statutory complaint upheld against you or have you had membership of this Association, or similar organisation, refused or terminated?	YES / NO
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Do you consent to ADA SA to provide practice details to prospective patients seeking treatment from you?	YES / NO
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I declare that the information I have provided is true and correct.

**Signature:**

**Dated:**

Please provide names of two professional referees, both must be members of the Australian Dental Association. These referees will be contacted by ADA SA to provide written references to support your application

Sponsor 1

Sponsor 2

Or if transferring, State transferring from

**Please return with payment to ADA SA, PO Box 858, Unley, SA 5061  
If you require assistance or have any questions please call 08 8272 8111**

### FOR OFFICE USE ONLY

Date Received		Date Entered to iMIS		ADASA Membership No.	
ADA SA Category		ADA Inc Category		Guild Category	
Newsletter Issue		Council Date		Council Approved	
Invoice Number		Payment Received			
Referee 1 – Letter Sent		Referee 1 Received			
Referee 2 – Letter Sent		Referee 2 Received			
Date Federal Informed		Date Guild Informed			