



**MEMBERSHIP APPLICATION**

Name \_\_\_\_\_ Mailing  
Address \_\_\_\_\_ Primary  
Phone \_\_\_\_\_ Alternate phone \_\_\_\_\_ Business  
Name and Address \_\_\_\_\_ Business  
Phone & Email \_\_\_\_\_ Current WA  
Denturist License# \_\_\_\_\_ Date of Initial WA License \_\_\_\_\_ Are/were you  
licensed or certified in another state or province? No/Yes- List State(s) and Lic # (s): \_\_\_\_\_ Please  
list any denturist schools/programs you have attended, and the dates of attendance:

Additional Comments: \_\_\_\_\_

**PLEASE SELECT THE TYPE OF MEMBERSHIP FOR WHICH YOU ARE APPLYING**

- **\*New Full Membership:** \$500 per year (first year only). Full Membership benefits include: reduced rates for continuing education, membership to the National Denturist Association after 6 months of continuous attendance with WDA, patient referrals through our toll-free number and website, reduced rates on malpractice insurance, access to the Peer Review resolution process, newsletter, and full voting power within the association.  
*(Membership benefits are subject to change, please consult the Executive Director for list of current benefits).*  
\*NEW MEMBERS SUBJECT TO APPROVAL\* RECOMMENDATION FROM CURRENT WDA MEMBER MAY BE REQUESTED\* Reference name and phone: \_\_\_\_\_
- **Renewal of Full Membership:** \$1000 per year (or \$900 if paid in full during January of membership year).
- **Associate Membership:** \$600 per year. Associate memberships are offered to retired denturists, spouses, and non-denturists.
- **Student Membership:** Free with current enrollment in an approved Denturist program, unlicensed students only, limitations and exclusions may apply, see current bylaws for details.

IMPORTANT! PLEASE READ AND SIGN BELOW: I understand that in order to become a member of the WDA, I must have an existing member sponsor me. A letter of recommendation from my sponsor must accompany my application. My sponsor may be required to address the board on my behalf. I understand that my membership application is subject to approval by the board.

**By submitting my application, I agree to abide by and uphold the ideals and bylaws of the Washington denturist Association, in its endeavor to unite, protect and further the profession.**

I understand that my dues need to be current in order to receive the benefits of membership. Reduced, prepaid rates apply only to memberships paid in full during the month of January for that year. If dues go unpaid for 90 days, my membership will be terminated automatically. I fully understand and accept the responsibility of my dues, and if my membership is terminated as a result of non-payment, that I will still be held responsible for payment of any past due amount. If following termination due to non-payment, any reinstatement of membership would require prepayment of one year's dues.

**I certify that all statements above are true, and complete to my knowledge.**

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