

C.A.V.A.D.
California Association of Vietnamese American Dentists
MEMBERSHIP APPLICATION

P.O. Box 2129, Westminster, CA 92684-2129

Name (Last, Middle, First): _____

Address (Street, City, State, Zip): _____

_____ E-mail: _____

Phone: (____) _____ - _____ Fax: (____) _____ - _____

State license no.: _____ Year Graduated: _____ School: _____

I authorize CAVAD to send notices to me by one or more of the following methods (check all that applies):
_____ mail _____ facsimile _____ e-mail

I understand that CAVAD may only release my *name and address* to its members, other individuals and entities as authorized by the board. With respect to the other information listed above, I (check one that applies) _____ authorize or _____ do not authorize CAVAD to release such information to its members, other individuals, or entities.

I (check one that applies) _____ authorize or _____ do not authorize CAVAD to list my name among the CAVAD members on its website at www.cavad.org. If you want to receive CE announcements please include your email address in the space above.

I certify under the penalty of perjury that I meet the admission criteria for the category marked below:

<u>Dues</u>	(Check one)	<u>Category</u>
\$50	_____	Member *
\$50	_____	Practicing affiliate **
\$5	_____	Non-practicing affiliate ***

* A **member** must be a practicing dentist, currently licensed to practice in California, whose ethnic background is Vietnamese, and whose license is not suspended or revoked by the California Dental Board.

** A **practicing affiliate** must be a practicing dentist who does not qualify as a member, currently licensed to practice in the United States, and whose license is not suspended or revoked by the applicable dental board.

*** A **non--practicing affiliate** must be a retired or non-practicing dentist.

You can choose to pay more than the required due to show your support for CAVAD. Please attach a check payable to the order of CAVAD for the applicable due, or fill out credit card information below (**Visa or Master Card only**):

Name as on credit card (first, middle initial , last): _____

Credit card: (circle one) VISA or MC Credit card number: _____

Contact phone no: _____ Exp. date: _____

Billing address: (Street, City, State, Zip): _____

Authorized charge amount: _____ Signature: _____

Please return the complete application and appropriate due to C.A.V.A.D., P.O. Box 2129, Westminster, CA 92684-2129 or fax it to (949) 856-9971.

