



Membership Application Form



We/I hereby make application for membership in the

- LOUISIANA DENTAL LABORATORY ASSOCIATION, INC.*
- MISSISSIPPI DENTAL LABORATORY ASSOCIATION, INC.**

Name: _____
 Name of Laboratory _____ CDL? _____
 Address: _____ City: _____ State: _____ Zip Code: _____
 Phone: _____ Fax: _____ Email: _____
 # Years in Lab Business: _____ # Years at this location: _____ Proprietorship? _____ Corporation? _____ Partnership? _____
 Total # of employees: _____ Total # of Technical: _____ Total # of Non-Technical: _____
Departments: Check all services that are performed in your lab:
 _____ Dentures _____ Partial Dentures _____ Crown & Bridge _____ Ceramics _____ Ortho
 Name of Owner(s)/Partner(s): _____ CDT? _____
 Name of Person(s) authorized to vote for lab at business meetings in designated voting order (if applicable): _____

In submitting this application, we understand it is our responsibility to become familiar with the contents and meaning of the constitution and bylaws of the State Association, and all laws, ordinances, or public regulations concerning the dental arts, and to abide thereby; and further, that it is our duty to participate in the affairs and activities of said Association. Further, it is understood for annual dues to continue to accrue until our membership is formally terminated in accordance with the bylaws of the Association.

Signature: _____ **Date:** _____

*LOUISIANA DENTAL LABORATORY ASSOCIATION, INC.

_____ Laboratory _____ Associate (Individual) _____ Associate (Lab) _____ Student

Laboratory: (Lab owners): includes state only privileges and dues. Lab is member and is entitled to one vote. All employees may enjoy discounts at meetings.

Dues: 1-2 employees \$154; 3-5 \$181.50; 6-10 \$209; 11-20 \$236.50; Over 20 \$264

Associate: Educator, Manf. or Supplier Representative, Tech. in Non Mbr. Lab, out of state tech/lab; Schools of Dental Tech.; mbr of another state component. (Lab owners located in LA may not use this type of membership) Non-voting. Dues expire with end of calendar year.

Dues: \$66/yr. for individual; \$120/yr. for entire lab/company

Student: (Individual) - must be enrolled in ADA accredited Dental Technology program. Non voting. Dues expire with end of calendar year.

Dues: \$16.50/yr.

Full year dues must accompany application. Quarterly payment is permissible for renewals for Laboratory Members.

For Louisiana Only:

Payment Method: _____ Check (made payable to LDLA) _____ Visa _____ MasterCard Total Amount Authorized: \$ _____

Cardholder Name: _____ Signature: _____

Card #: _____ Exp. Date: _____

For Visa or MasterCard, enter 3 digit number from back of card - usually in signature block - (following credit card number) _____ (Required)

Credit Card Statement Address: _____ Zip Code: _____

Please return application to:

Louisiana Dental Laboratory Association, Inc. • PO Box 206 • Elkin, NC 28621
 Phone: 336-835-9251 • Fax: 336-835-9243 • Website: www.ldla.org • Email: contactus@ldla.org

**MISSISSIPPI DENTAL LABORATORY ASSOCIATION, INC.

_____ Full Member _____ Associate (Individual) _____ Associate (Lab)

Full Member: Dental Laboratory owners or Managers of established, ethical, commercial dental laboratories operating in the state of Mississippi. Lab is member and is entitled to one vote. All employees may enjoy discounts at State Association sponsored meetings.

Dues: \$150/yr. Dues are on a calendar year basis.

Associate Member: IF YOU MEET THE CRITERIA FOR FULL MEMBERSHIP, YOU DO NOT QUALIFY FOR THIS CATEGORY.

Suppliers, salesmen, students, dentists, out-of-state lab technicians and other friends of the dental laboratory industry (providing they are not owners or co-owners of a dental laboratory) are eligible for this category. May not vote or hold office.

Dues: \$66/yr. (individual) \$120/yr. (company lab) Dues are on a calendar year basis.

For Mississippi Only:

Payment Method: _____ Check (made payable to MDLA) _____ Visa _____ MasterCard Total Amount Authorized: \$ _____

Cardholder Name: _____ Signature: _____

Card #: _____ Exp. Date: _____

For Visa or MasterCard, enter 3 digit number from back of card - usually in signature block - (following credit card number) _____ (Required)

Address for Credit Card Statement: _____ Zip Code: _____

Please return application to:

Mississippi Dental Laboratory Association, Inc. • PO Box 206 • Elkin, NC 28621
 Phone: 336-835-9251 • Fax: 336-835-9243 • Website: www.msdl.org • Email: wanda@cmal.pro