

**American Dental Hygienists' Association**  
**Application Procedures for Members with Disabilities**  
**Membership Category**

Individuals who apply for this category of membership must submit the following information to the Division of Member Services:

- ***Photocopy of current dental hygiene license.***
  
- If the individual is not a current member, ***verification of past membership*** must be verified by ADHA's Central Office. If Central Office does not have verification of past membership, a letter from the individual's former constituent or component verifying previous membership must be submitted.
  
- ***A completed Membership Qualification Form*** from the individual's physician must be submitted. On the form, the physician is asked to indicate whether the disability is permanent or temporary, and that the individual is not currently able to be employed because of the disability.
  
- If the disability is considered by the physician to be permanent but the individual may eventually be able to undertake some type of employment ***OR*** if the disability is temporary, the photocopy of license and membership qualification form must be submitted every year prior to renewal at the 25% dues rate. A reminder will be sent to the member prior to the dues billing. If the license and form are not submitted, the member will automatically be invoiced at the Active member rate.

Materials should be submitted to:

American Dental Hygienists' Association  
Division of Member Services  
444 North Michigan Avenue  
Suite 3400  
Chicago, IL 60611

800-243-2342  
Fax 312-467-1806  
www.adha.org  
member.services@adha.net



# Application for Members with Disabilities

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ADHA Membership ID

Please circle your credential:

RDH LDH Other: \_\_\_\_\_

Name (Last, First, Middle Initial)

Email Address

Maiden Name (if applicable)

Daytime Phone (include area code)

Street Address

Evening Phone (include area code)

City/State/Zip Code

Dental Hygiene School Attended

State Year of Graduation

Current License Number State

Please circle the highest educational level attained:

Certificate Associate Baccalaureate  
Master's Doctorate

### Annual Dues

National Dues \$ 38.75

Constituent Dues\* \$ \_\_\_\_\_  
(state)

Component Dues\* \$ \_\_\_\_\_  
(local)

Assessment\* \$ \_\_\_\_\_  
(if applicable)

**Total** \$ \_\_\_\_\_

**\*Call 800/243-2342 for correct dues amount.**

\$6.00 and \$5.00 of the annual ADHA membership dues are allocated for subscriptions to the *Journal of Dental Hygiene* and *Access*, respectively. Dues are not deductible as a charitable contribution for federal income tax purposes. They may be deducted as a business expense.

### Method of Payment

I am enclosing a check payable to ADHA for the amount of my annual dues. (see **Total**)

Please charge my annual dues to my credit card. (see **Total**)

VISA

MasterCard

Card Number

Expiration Date

Name as it appears on the card (Please Print)

Signature

Date

**DUES ARE NONREFUNDABLE**

**American Dental Hygienists' Association  
Members with Disabilities Qualification Form**

**Applicant Information** *(please print or type)*

ADHA Membership ID: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Telephone Number:(day) \_\_\_\_\_ (evening) \_\_\_\_\_

Name of Physician completing the form: \_\_\_\_\_

I verify that the applicant named above currently has a disability and is unable to be employed.

Yes       No

*Describe the disability:* \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Is the nature of the disability such that: *(check one)*

\_\_\_\_\_ This disability is temporary and the individual will eventually resume previous work duties.

\_\_\_\_\_ This disability is permanent and, although not currently working, the individual will eventually be able to return to some kind of employment (dental hygiene-related or otherwise).

\_\_\_\_\_ This disability is permanent and the individual will never be able to be employed,

Please return this form to the applicant named above. This information will be used only to qualify the individual for a membership category within the American Dental Hygienists' Association.

Physician Signature: \_\_\_\_\_

Date: \_\_\_\_\_