

INTRODUCING CDLA's 2007

LOW-COST EDUCATION PACKAGE

FEATURING A 3- CLINIC SERIES

Saturday April 21 Leading U.S. Clinician Peter Pizzi, CDT, MDT, TFNGS Training Session was a great Success	Saturday Sept. 29 Noted Prosthodontist Dr John Robert Kelly	Saturday Oct. 10 <u>NEW!</u> Manufacturer's Series
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I (we) wish to register for CDLA's 3-Clinic Comprehensive Education Package in 2007. All are approved for CDT credits. All clinics held at Uconn Health Center, Friendship Hall, Farmington, CT

Name(s) _____
Lab Name _____
Street Address _____
City _____ Zip _____ Phone () _____

CDLA
1771 Post Road East
Suite 131
Westport, Connecticut 06880

Connecticut Dental Laboratory Association

MEMBERSHIP APPLICATION / RENEWAL FORM

DENTAL LABORATORY APPLICATION / RENEWAL	TECHNICIAN /ASSOCIATE MEMBER APPLICATION / RENEWAL
Please type or print.	
Name of Laboratory <input type="radio"/> New Applicant <input type="radio"/> Renewal	Name of Applicant <input type="radio"/> New Applicant <input type="radio"/> Renewal
Owner: _____ Address: _____ City: _____ State: _____ Zip: _____ Phone: () _____ E-Mail: _____	Technician Membership Laboratory Employed _____ Address _____ City _____ State _____ Zip _____ Phone () _____ Fax () _____ E-Mail _____ CDT <input type="radio"/> Yes Year Experience _____ <input type="radio"/> No
Each Active Member laboratory must name a designated representative, who will have voting privileges for that laboratory and will be eligible to serve on state and national offices and committees. _____ CDT <input type="radio"/> Yes <input type="radio"/> No _____ CDT <input type="radio"/> Yes <input type="radio"/> No (Designated Laboratory Representative(s))	Associate Membership Company Where Employed _____ Address _____ City _____ State _____ Zip _____ Phone () _____ Email _____ Mailing Address if Different: Address: _____ City _____ State _____ Zip _____ Phone () _____ E-Mail _____
Type of Ownership <input type="radio"/> Sole Proprietorship <input type="radio"/> Partnership <input type="radio"/> Corporation	Student Member CDT <input type="radio"/> Yes Address _____ City _____ State _____ Zip _____ Phone () _____ E-Mail _____ School Where Enrolled _____
Services Offered <input type="radio"/> Crown & Bridge <input type="radio"/> Complete Dentures <input type="radio"/> Orthodontics <input type="radio"/> Ceramics <input type="radio"/> Cast Partial <input type="radio"/> Full Service	
Number of Technicians: _____ Years in Business: _____	I hereby apply for Active membership in the Connecticut Dental Laboratory Association. I meet all the requirements for membership as set forth in the Bylaws of the Association and further do hereby agree to abide by these same Bylaws.
DUES <i>Laboratory Members:</i> \$200.00 <i>Technician Members:</i> \$ 50.00 <i>Associate Member:</i> \$ 60.00 <i>Student Member:</i> \$ 30.00 TOTAL DUE: \$ _____	Signature _____ Date _____
SEND TO: Connecticut Dental Laboratory Association C/O County Dental Lab 53 East Ave. Norwalk, CT 06851 (203) 847-0298	