



American Dental Hygienists' Association Application Procedures for Members with Disabilities

Individuals who apply for this category of membership and are not able to work in any of the 6 roles of the dental hygienist (Clinician, Educator, Researcher, Administrator/Manager, Advocate, Public Health) 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 in any of the 6 roles of the dental hygienist 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 75% 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

312-440-8900
Fax 312-467-1806
www.adha.org
member.services@adha.net



Application for Members with Disabilities

ADHA Membership Number

Please circle your credential
RDH LDH Other: _____

Full Name

Email

Street Address

Home/Work Phone

City, State, Zip

Annual Dues

National Dues \$ 131.25

Constituent Dues (state)* \$ _____

Component Dues (local)* \$ _____

Assessment* (if applicable) \$ _____

Total \$ _____

*Call 312-440-8900 for correct dues amount.

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



Members with Disabilities Qualification Form

Applicant Information (*please print or type*)

ADHA Membership ID: _____

Name: _____

Address: _____

City, State, Zip: _____

Preferred Telephone Number: _____

Name of Physician completing the form: _____

I verify that the applicant named above currently has a disability and is unable to be employed in the 6 roles of a dental hygienist (Educator, Researcher, Administrator/Manager, Advocate, Clinician, and Public Health):

Yes

No

Briefly 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 (in 6 roles of dental hygienist as described above 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 only be used to qualify the individual for a membership category within the American Dental Hygienists' Association.

Physician Signature: _____

Date: _____

Professional Roles of the Dental Hygienist

