



Illinois State Dental Society Dental Hygienist Membership Application

Name _____

Illinois License Number _____

Home Address _____

City: _____ State: _____ Zip: _____

Primary Employer / dentist name: _____

Office Address _____

City, State, Zip _____

Phone Numbers: Home: _____ Office: _____

Fax: _____

Preferred Mailing Address (check one) Home Office

e-mail address: _____

**Mail \$50 check payable to: ISDS - P.O. Box 376 – Springfield, IL 62705 or
charge to your credit card and fax back to 217/525-8872.**

Name on Card: _____

VISA, MasterCard, Discover or AMEX # _____

Expiration Date: _____

Your Credit Card Billing Address: _____

Signature Security Code: _____