Authorised Contact Form Practice Manager

ADA Member details

Principal dentist / ADA member name:	
ADAVB/TAS membership number:	
Practice name:	
Practice address:	

ADA Member declaration

I authorise my practice manager (whose name is given below) to contact the ADAVB to seek information in relation to practice management matters concerning the practice and to have access to www.adavb.org to view resources and register for events on their or my behalf.

ADA Member signature:	Date:

Authorised contact (Practice manager) details

Full name:	
Position title:	
Contact phone number:	
Email address:	

Practice manager declaration

If I change employment/dental practice I will contact the ADAVB to update or cancel my website access.

Practice manager signature:	Date:

On completion please return this form to practiceplus@adavb.org