

# 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](http://www.adavb.org) to view resources and register for events on their or my behalf.*

ADA Member signature:	Date:
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## 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:
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