



IFDH Full Association Membership Application

✓ Yes, we are interested in becoming a Full Association member of the IFDH.

Contact & Information

Please print in English

Organization _____

Address _____

City _____ State _____ Zip/Postal _____

Country _____

Phone _____ Fax _____

Contact: First Name _____ Last Name _____

Title _____ Email _____

of Hygienists/Therapists in your: Country _____ Organization _____

Delegates to IFDH to be:

- First Name _____ Last Name _____ Email _____

- First Name _____ Last Name _____ Email _____

Please notify us if either of the two representatives above change.

See pages 2 and 3 for Required Information, Attachments and Payment Options →→

Upon approval of your application, a membership invoice will be sent to you with the amount based on the number of dental hygienist and therapist members.

For More Information, Contact:

Peter Anas, Executive Director director@IFDH.org or Phone: +1-240-778-6790

Send Completed Forms to:

The International Federation of Dental Hygienists
100 South Washington Street, Rockville MD 20850, USA

OR Email: membership@IFDH.org **OR Fax to:** +1-240-778-6112

Required Information and/or Attachments

Please include with your application **ALL** of the following information **in English**:

- Copy of the Statutes, Constitution and By-Laws of the national dental hygienists association.
- Declaration that the applicant organization officially supports the Human Rights Statement of the International Federation of Dental Hygienists on your official letterhead signed by the President.
- List of legislated professional duties provided for patient care (please attach separate sheet)
- Documentation that the applicant organization is the official national association which represents the registered/licensed dental hygienists in that country e.g. registering authority, Labor Department or other Government Agency.

Your Delegates:

- Will your IFDH 2 delegates have served on your organization's Board of Directors? Yes No
- How does your country's national organization select its 2 delegates to IFDH?
 Appointed Elected Other (details) _____
- If you answered "Appointed" or "Elected" above, provide details or criteria

- How often will your delegate's position be selected/changed? _____

Education: You may attach a separate page answering some of these questions:

- What are the official titles of the oral health professionals in your country (not including dentists, dental prosthetists and dental assistants/ nurses)
 Dental Hygienists Dental Therapists Oral Health Therapists Other _____
- Provide the # of each of above in your country:
 - Dental Hygienists _____
 - Dental Therapists _____
 - Oral Health Therapists _____
 - Other _____
- How many oral health education programs are there in your country? _____
- Which level of educational institution? 1. Select all that apply. 2. List the certificate/degree attained (Master's, Bachelor's, Diploma, Certificate, etc.) AND 3. The length of the program (years).
 - University _____
 - Community College _____
 - Training School _____
 - Hospital _____
 - Other _____
- Qualifications attained e.g. Diploma, Certificate, Degree etc
- Summarize the graduate oral health practitioners' scope of practice (on separate page).
- What are the pre-requisites for dental hygiene education? e.g. secondary school, dental assisting.

Payment

- One-time \$125 (US) application fee.

Payment Details (please check one):

- Bank Cashier's Check or Money Order in \$US (**Make payable to IFDH**)
Mail to our address on page 1
- Transfer from your bank to:
 - Intermediary Institution: Pacific Coast Bankers' Bank, Walnut Creek, CA, 94596, USA
 - ABA: 121042484
 - SWIFT Code: PCBBUS66
 - Beneficiary Bank: Revere Bank, 319 Main Street, Laurel, MD, 20707, USA
 - Account #: 055003528
 - Beneficiary Customer: Intl Federation of Dental Hygienists
 - Account#: 1758449501

Name of your bank: _____

Branch: _____

Address: _____

Account Name: _____ Sort Code: _____

Transfer date/reference: _____

- Credit Card (Fax to +1.240.778.6112. **OR** Enter information below, scan and email to membership@ifdh.org)

Check One: MasterCard Visa American Express

Cardholder's Name (print as it appears on card): _____

Credit Card #: _____ Expiration Date: _____

Cardholder's Signature: _____

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For IFDH Use Only:

Received Date _____

Approval by Membership Committee Date _____