



# Membership Application

## Dental Organization for Sleep Apnea

### Member Information (please print or type)

Name *	
Title *	
Specialty	
Billing address *	
City *	
State *	
ZIP Code *	
Telephone (home) *	
Telephone (business) *	
Fax	
E-Mail *	
Website	
Choose a Login Name *	
Choose a Password *	

**(\*) All of this information must be provided in order to process your application**

### Payment Information

Type of Membership

Founding Member, \$1,000.00

Regular Member, \$300.00 Annually

I am paying by:

Regular Member, \$25.00 month (must apply on-line only)

money order

check

credit card

Credit card type	
Credit card number	
Card Verification Number	
Expiration date	
Authorized signature	

If Paying with Credit Card, fax completed form to 1-888-285-3244

If paying by Check or Money Order, please make payable to **DOSA** and mail with this form to:

**Dental Organization for Sleep Apnea (DOSA)**  
P.O. Box 5427 Granbury, TX 76049-0427 Attn: Walt Helgesen  
1-888-285-3244

**1309 Paluxy Road, Granbury, TX 76048 (888) 285-3244**  
**www.apneadocs.com e-mail: info@apneadocs.com**