



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

Annual Dues, \$300.00/year Monthly Dues, \$25.00/month (must apply on-line only)

I am paying by:

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)
1309 Paluxy Road, Granbury, TX 76048 1-888-285-3244

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www.apneadocs.com e-mail: info@apneadocs.com