AMERICA'S PEDIATRIC DENTISTS
THE BIG AUTHORITY on little teeth

AAPD Postdoctoral Student Membership Application

211 East Chicago Avenue, Suite 1600, Chicago, Illinois 60611 • (312) 337-2169 • Fax (312) 337-6329

Please print. Must be enrolled in a pediatric residency program approved by Commission on Dental Accreditation of the American Dental Association (CODA).

Personal Information

Name: _____
FIRST MIDDLE LAST

Directory Address: _____

City: _____ State: _____ Zip: _____

Phone:(_____) _____ Fax: (_____)_____

E-mail: _____ Website: _____

Mailing Address _____

City: _____ State: _____ Zip: _____

Phone:(_____) _____ Fax: (_____)_____

Gender: ❑ M ❑ F DOB: __/__/__ US Citizen: ❑ Y ❑ N

Professional Information

Member of: ❑ American Student Dental Association #_____
❑ Foreign Equivalent # _____
Transfer to Postdoctoral Membership? ❑ AAPD Member # _____
Previous Membership Class

❑ PreDoc
❑ Affiliate

Education

All students must list school and expected completion date of program.

	Date of Completion	School	Degree
Undergraduate			
Dental School			
Pediatric Dentistry Postdoctoral/Residency Training			
Other Dental Postdoctoral Training			
Additional Degree			

Signature: _____ Date: _____
If you are applying for an extension or transfer, your Program Director must send verification of your enrollment to the Headquarters Office.

Headquarters Office use only
Previous AAPD Membership: _____ Anticipated completion date: _____ Extended to: _____
❑ Approved ❑ Denied Reason: _____
Signed: _____ Date: _____