AAPD Predoctoral Student Membership Application

Annual dues: $27. Application will not be processed without payment.

Personal Information

Name: _____

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 # _____
- ❑ National Dental Association # _____
- ❑ Foreign Equivalent # _____

Education

	Date of Completion	School	Degree
Undergraduate			
Dental School			

Payment

My check is enclosed with payment ❑

Please charge my ❑Visa ❑Master Card ❑AMEX

Credit Card # _____ Exp. Date _____

Signature _____

Mail Application to:

American Academy of Pediatric Dentistry
211 E. Chicago Avenue, Suite 1700
Chicago, IL 60611
Attn: Membership
Ph: (312) 337-2169 Fx: (312) 337-6329

Headquarters Office use only

Previous AAPD Membership: _____ Anticipated completion date: _____ Extended to: _____

❑Approved ❑Denied Reason: _____

Signed: _____ Date: _____