



AAPD Postdoctoral Student Membership Application

Please print. No application fee required.

Personal Information

Name: _____
Last First Initial

Directory Address: _____
 City: _____ State: _____ Zip: _____
 Telephone: (_____) _____ Social Security No.: _____
 Fax: (_____) _____ E-mail address: _____
 Mailing Address: _____
 City: _____ State: _____ Zip: _____
 Telephone: (_____) _____
 Male Female Birthdate: _____ Birthplace: _____

Professional Information

Member of: American Student Dental Association # _____
 National Dental Association # _____
 Foreign Equivalent _____

Are you applying for: Student Membership? Full-time Part-time
 Extension of Student Membership? Reason: _____
 Indicate additional postgraduate program under Professional Training below
 Transfer to Postdoctoral Student Membership?
 Indicate accredited pediatric dental training program you are enrolling in: _____
 (Also list under Professional Training below)

Professional Training

(Month and Year)

	Institution	Began Program Date	Graduation Date (or anticipated)	Degree/Certificate
Dental				
Accredited Pediatric Dental Training				
Other Degrees/Advanced Training				
Postgraduate Program				

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: _____