AAPD Predoctoral Student Membership Application

Please print. $27 annual dues.
Application will not be processed without payment.

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 _____

Education

	Institution	(Month and Year) Began Program Date	Graduation Date (or anticipated)	Degree/Certificate
Dental				

Payment

☐ My check is enclosed with payment
Please charge my ☐ Visa ☐ MasterCard Credit Card #_____ Exp. Date _____
Signature _____

Mail or fax application to:
American Academy of Pediatric Dentistry
211 E. Chicago Ave. – Ste.1700
Chicago, IL 60611-2263
Phone: 312-337-2169 Fax: 312-337-6329

Signature:_____ Date: _____

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