

Home Information:

Preferred Mailing/Billing Address (Choose only one)

Address Line 1

Address Line 2

City

State

Postal Code

Country

Phone

Fax

E-mail ***Required for communication purposes**

Spouse Information:

Print Spouse's Name in the Membership Directory

First Name

Middle Initial

Last Name

Education: Degrees Earned (check all that apply):

DDS

DMD

DVM

Ph.D.

MS

MA

MSD

MPH

Additional Degrees: _____

Dental School Attended

State

Country

Graduation Date

Additional Training Program

State

Country

Graduation Date

Professional Information:

Are you currently an ADA Member?

Yes

No

What other professional organizations are you a member of? _____

Faculty Appointment:

Undergraduate Faculty Position/Title: _____

Institution: _____

% Time Teaching Undergraduate: _____

Postgraduate Faculty Position/Title: _____

Institution: _____

% Time Teaching Postgraduate: _____

ACP Membership Directory Listing:

Print my *Name Only* in the Membership Directory (excludes ALL contact information)

Choose any combination from the following options:

Print *University/Institution Address* (includes complete University/Institution contact information)

Print *Secondary Office Address* (includes complete Secondary Office contact information)

Print *Home Address* (includes complete Home contact information)

Communications: Please review the communication options carefully. If you have additional questions, or concerns please contact Membership Services for clarification.

- The ACP occasionally makes available its members' addresses (excluding telephone and e-mail) to vendors who provide products and services to the association community. If you do **not** wish to be included in these lists, please check this box.
- No ACP e-mail promotions. (By checking this, you limit promotional e-mails for ACP products and services; however, you will continue to receive general communications from the ACP such as the *Journal of Prosthodontics*, *Messenger*, etc.)
- No ACP mail communications or promotions. (By checking this box, you will **not** receive substantive membership benefits like the *Journal of Prosthodontics*, *Messenger*, or the Annual Session registration brochure.)

Applicant's Verification:

I hereby certify that the information on this application is correct. Your signature will also confirm your communication preferences listed above.

Applicant's Signature: _____ Date: _____

Qualifications for Membership:

Academic Alliance Membership in this College shall be limited to those individuals who have NOT completed an advanced dental education program in prosthodontics accredited by the Commission on Dental Accreditation of the American Dental Association. These individuals whose credentials include a DDS, DMD or Ph. D. and who currently hold an academic teaching appointment within an ADA accredited prosthodontic program or an undergraduate teaching position in the discipline of Prosthodontics may apply. Applicant must be an instructor spending a minimum of 50% of their time teaching as defined by the institution. (Applicants with special circumstances outside of the qualifications outlined for membership may request a special action of the Board of Directors.)

For consideration the following must accompany your application:

1. Application and/or Reinstatement fee: \$125 non-refundable
2. Dues: Annual Dues is \$472.00 per calendar year.
3. A letter of endorsement from an active College member and letter of verification of the applicant's teaching position from the Department Chair or Dean.

Method of Payment:

American Express _____	VISA _____	MasterCard _____	Check Enclosed _____

Card Holder's Name (Please print)			

Card Holder's Signature			

Credit Card Number		Expiration Date	
_____		_____	

Mail or fax your completed application, payment and letter of endorsement/verification to:

American College of Prosthodontists
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www.prosthodontics.org
cbaker@prosthodontics.org