



ACP Academic Alliance Membership Application

Please type or print clearly. An incomplete application will delay activation of membership.

First Name Middle Initial Last Name

Date of Birth Gender (check one): [] Male [] Female

Primary Office Information: [] Preferred Mailing/Billing Address (Choose only one)

Company/Institution

Title

Address Line 1

Address Line 2

Address Line 3

City State Postal Code + four Country

Phone Fax

E-mail (Required for communication purposes.) Web site

Secondary Office Information: [] Preferred Mailing/Billing Address (Choose only one)

Company Name

Address Line 1

Address Line 2

Address Line 3

City State Postal Code + four Country

Phone Fax

E-mail

questions, or concerns please contact Membership Services for clarification.

- The ACP occasionally makes available its members' addresses (excluding telephone and email) 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 emails for ACP products and services; however, you will continue to receive general communications from the ACP such as the ACP Journal of Prosthodontics.)
- No ACP mail communications or promotions. (By checking this box, you will not receive substantive membership benefits like the Journal of Prosthodontists or the Messenger or the Annual Session Registration Brochures.)

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 instructors 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/Reinstatement fee: \$125 non-refundable
- 2) Dues: If joining after July 1, the dues are ½ the normal annual rate. For dues pricing, please contact Carla Baker, associate executive director, at cbaker@prothodontics.org or by phone at (312) 573-1260, ext. 222.
- 3) A letter of endorsement from an Active College Member must be provided.
- 4) A 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)	
_____ Signature of Card Holder	
_____ Card Number	_____ Expiration Date

Mail or fax your payment, completed application and required documentation to:

**American College of Prosthodontists
211 E. Chicago Avenue, Suite 1000
Chicago, IL 60611
Phone: (800) 378-1260 Fax: (312) 573-1257
www.prothodontics.org**