

Home Information:

Preferred Mailing/Billing Address (Choose only one)

Address Line 1

Address Line 2

Address Line 3

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):

CDT RDT MDT Ph.D. MA BS BA Additional Degrees: _____

Dental Technician Program

State

Country

Graduation Date

Undergraduate Degree

University Attended

Graduation Date

Graduate Degree

University Attended

Graduation Date

Primary Activity:

Laboratory Owner

Laboratory Employee

Hospital Laboratory Employee

Procedures: (check all procedures that you perform in your office)

Fixed Dentures

Removable Dentures

Orthodontics

Maxillofacial

ACP Membership Directory Listing:

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

Choose any combination from the following options:

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

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

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

Find a Dental Technician: All member's office contact information is included in the ACP technician referral Web site "**Find a Dental Technician**" for consumers, patients and professionals.

I **do not** wish to be included in the ACP "Find a Technician" professional referral Web site.

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:

Alliance members in this College shall be limited to those individuals who have completed a formal training program in Dental Technology and are sponsored by an ACP member OR technicians who have not completed a formal training program may qualify if they are sponsored by two ACP members. For special circumstances, please contact the Central Office for approval options.

For consideration the following must accompany your application:

1. Application and/or Reinstatement fee: \$125 non-refundable
2. Dues: Annual Dues is \$350.00 per calendar year.
3. Copy of your certificate indicating that you have successfully met the requirements of the National Board of Certification in Dental Technology (NBC).
4. A letter of recommendation from a current member of the American College of Prosthodontists. (For assistance identifying current members, please contact Carla Baker, associate executive director, cbaker@prosthodontics.org)

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, certificate and sponsor/recommendation information to:

American College of Prosthodontists
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Phone: (800) 378-1260 Fax: (312) 573-1257
www.prosthodontics.org
cbaker@prosthodontics.org