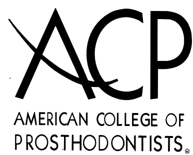

Dental Technician Alliance Application

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

Spouse Information: ☐ Print Spouse's Name in the Membership Directory

First Name Middle Initial Last Name

Home Information: ☐ **Preferred Mailing/Billing Address (Choose only one)**

____

Address Line 1

____

Address Line 2

____

Address Line 3

City	State	Postal Code + four	Country

Phone	Fax

____

E-mail

Primary Activity: ☐ Laboratory Owner ☐ Laboratory Employee ☐ Hospital Laboratory

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

☐ Fixed Dentures ☐ Removable Dentures ☐ Orthodontics ☐ Maxillofacial

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 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 Prosthodontics* or the *Messenger* or the Annual Session registration brochure.)

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.

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:______________________

Education:

Degrees Earned (check all that apply): ☐ CDT ☐ RDT ☐ MDT ☐ MA ☐ BS ☐ BA

Dental Technician Program	City	State	Country	Year of Graduation
Other Training Program	City	State	Country	Year of Graduation

Undergraduate Degree	University Attended	Year of Graduation
Graduate Degree	University Attended	Year of Graduation

Sponsor:

Name ______________________ Company ______________________

Address ______________________ City ________ State ____ Zip ________

Sponsor's Signature ______________________

Qualifications for Alliance Status

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 Headquarters Office for approval options.

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) Copy of your certificate indicating that you have successfully met the requirements of the National Board for Certification.
4) The letter of recommendation from a current member of the American College of Prosthodontists. (For assistance identifying ACP Members, please contact Carla Baker.)

Method of Payment

Check Enclosed: _______ VISA_______ MasterCard_______ American Express ________

Card Holder's Name (Please Print) ______________________

Card Number ______________________ Expiration Date ________

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Chicago, IL 60611
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