



ACP Global 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

Undergraduate Faculty Position

Position: _____ % Time Teaching Undergrad. _____

I am the Prosthodontic Department Chair

Institution _____ State _____

Post-Graduate Faculty Position

Title: _____ % Time Teaching Post-Graduate: _____

I am the Prosthodontic Program Director

I am the Maxillofacial Program Director

Institution _____ State _____

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

I do not wish to be included in the ACP "Find a Prosthodontist" patient 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: _____

Qualifications for Membership

Global Alliance Membership in this College shall be limited to those individuals who have completed an advanced dental education program in prosthodontics that is not accredited by the Commission on Dental Accreditation of the American Dental Association.

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@prosthodontics.org or by phone at (312) 573-1260, ext. 222.
- 3) Copy of your certificate indicating that you have successfully completed an advanced dental education program in prosthodontics. The program must NOT have been accredited by the ADA's Commission on Dental Accreditation at the time you completed your program.

Method of Payment

American Express _____ VISA _____ MasterCard _____ Check Enclosed _____	
_____ Card Holder's Name (Please Print)	
_____ Signature of Card Holder	
_____ Card Number	_____ Expiration Date

For all membership questions or concerns, please e-mail Carla Baker at cbaker@prosthodontics.org.

Mail or fax your payment and application to:

**American College of Prosthodontists
Attention: Carla Baker, Associate Executive Director
211 E. Chicago Avenue, Suite 1000
Chicago, IL 60611
Phone: (800) 378-1260
Fax: (312) 573-1257
www.prosthodontics.org**