



Your smile.
Our specialty.™

American College of Prosthodontists
Membership Application

Please type or print clearly. (An incomplete application will be returned and will delay activation of membership.)

I am applying as a (check one): [] Member [] Fellow

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 Country

Phone Fax

Email * Required for communication purposes

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 Country

Phone Fax

Email * Required for communication purposes Website

Professional Information:

Are you currently an ADA Member? Yes No

What other professional organizations are you a member of? _____

Faculty Appointment (if applicable):

Undergraduate Faculty Position/Title: _____

Institution: _____ % Time Teaching Undergraduate: _____

I am the Prosthodontic Department Chair

Postgraduate Faculty Position/Title: _____

Institution: _____ % Time Teaching Postgraduate: _____

I am the Prosthodontic Program Director

I am the Maxillofacial Program Director

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 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 email 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 *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.*)

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 Website "*Find a Prosthodontist*" for consumers, patients and professionals.

I do **not** wish to be included in the ACP "Find a Prosthodontist" patient referral Website.

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:

Active Membership in this College shall be limited to those individuals who have completed an advanced dental education program in prosthodontics accredited by the Commission on Dental Accreditation of the American Dental Association.

Fellowship in this College shall be limited to those individuals who meet the qualifications for Active Membership, who are also Diplomates of the American Board of Prosthodontics holding a current annual certificate.

Students enrolled in accredited advanced dental education programs in prosthodontics **should not** complete this form. Contact the American College of Prosthodontists' Central Office for a Student Membership Application.

For consideration the following must accompany your application:

1. Application and/or Reinstatement fee: \$125 non-refundable.
2. Dues: Annual Membership Dues are \$696.00 per calendar year.
3. International Members should contact the ACP's Central Office for International Membership Dues rates.
4. Copy of your certificate indicating that you have successfully completed an advanced dental education program in prosthodontics. The program must have been accredited by the ADA's Commission on Dental Accreditation at the time you completed your program.
5. If you are applying for status as a Fellow, you *must* include a copy of your current annual certificate of Board certification.

Method of Payment:

American Express _____ VISA _____ MasterCard _____ Check Enclosed _____ _____ Card Holder's Name (Please print) _____ Card Holder's Signature _____ Credit Card Number _____ Expiration Date _____
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Mail or fax your completed application, payment and certificate to:

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