ACP AMERICAN COLLEGE OF PROSTHODONTISTS | Your smile. Our specialty.™

American College of Prosthodontists
Dental Technician Alliance Membership Application

Please type or print clearly. (An incomplete application will be returned and 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 Country

Phone Fax

Email * Required for communication purposes

Web site

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

Company/Institution

Address Line 1

Address Line 2

Address Line 3

City State Postal Code Country

Phone Fax

Email * Required for communication purposes

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

Email * 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 ☐ Dental Implants ☐ Caps/Crowns

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 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.)

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 $400.00 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, contact Carla Baker, Associate Executive Director at 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
211 E. Chicago Avenue, Suite 1000 Chicago, IL 60611
Phone: (800) 378-1260 Fax: (312) 573-1257
www.prosthodontics.org
cbaker@prosthodontics.org