



**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**

**Education:** Degrees Earned (check all that apply):

DDS    DMD    DVM    Ph.D.    MS    MA    MSD    MPH    BA    BS

Additional Degrees not listed above: \_\_\_\_\_

Dental School Attended

State

Country

Graduation Date

Prosthodontic Training Program

State

Country

Graduation Date

**Primary Activity:**

Private Practice

Military

Education

Veterans Administration

**Secondary Activity:**

Education

Administration

Consultant

Hospital Dentist

Research

**Faculty Appointment (if applicable):**

Undergraduate Faculty Position/Title: \_\_\_\_\_

Institution: \_\_\_\_\_ % Time Teaching Undergraduate: \_\_\_\_\_

Postgraduate Faculty Position/Title: \_\_\_\_\_

Institution: \_\_\_\_\_ % Time Teaching Postgraduate: \_\_\_\_\_

**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)

**Spouse Information:**

Print Spouse's Name in the Membership Directory

First Name

Middle Initial

Last Name

**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 Prosthodontic, 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:**

*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 and/or Reinstatement fee: \$125 non-refundable
2. Annual Global Alliance Membership Dues are \$495 per calendar year.
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:**

<p>American Express _____ VISA _____ MasterCard _____ Check Enclosed _____</p> <p>_____</p> <p>Card Holder's Name (Please print)</p> <p>_____</p> <p>Card Holder's Signature</p> <p>_____</p> <p>Credit Card Number _____ Expiration Date _____</p>
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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](http://www.prosthodontics.org) [cbaker@prosthodontics.org](mailto:cbaker@prosthodontics.org)