ACP
AMERICAN COLLEGE OF
PROSTHODONTISTS®

Student Application

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

First Name ____________ Middle Initial ____________ Last Name ____________

Date of Birth ____________ Gender (check one): ☐ Male ☐ Female

Office Information: ☐ **Preferred Mailing/Billing Address**

Company/Institution

Address Line 1

Address Line 2

Address Line 3

City | State | Postal Code + four | County | Country

Phone | Fax

E-mail (Required for communication purposes.)

Home Information: ☐ **Preferred Mailing/Billing Address**

Address Line 1

Address Line 2

City | State | Postal Code + four | County | Country

Phone | Fax | E-mail

Spouse Information:

First Name | Middle Initial | Last Name

☐ Print Spouse's Name in the Membership Directory (If you want like your spouse' name printed in the ACP Membership Directory, please check the box.)

My Spouse is an ACP Member ☐ yes ☐ no

ACP Communication Preferences:

- ☐ The ACP occasionally makes available its members' addresses (excluding telephone and e-mail) to vendors who provide products and services to the association. If you do not wish to be included in these lists, please check this box.
- ☐ No ACP e-mail promotions. (By checking this box, you limit promotional e-mails 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* or the *Messenger* or the Annual Session registration brochure.)

ACP Member Directory Preferences:

☐ Publish **name only** in the directory (No contact information will be included.)

Or choose any combination or all of the following options; please check all contact data you wish to have included in the ACP Membership Directory.

☐ Publish Office 1 ☐ Publish Home ☐ Publish Spouse's Name

Education:

Degrees Earned (check all that apply):

☐ DDS ☐ DMD ☐ MSD ☐ PhD ☐ MS ☐ MA ☐ BS ☐ BA ________________________
Additional

Dental School Attended	City	State	Country	Year of Graduation
Prosthodontic Training Program	City	State	Country	Expected Year of Graduation

Specialty Training Program is (check one): ☐Prosthodontics ☐Maxillofacial Prosthetics ☐Combined Maxillofacial & Prosthodontics

Other Training Program	City	State	Country	Yr. of Graduation

ABP Board Certified? ☐ Yes ☐ No Board Certification Date: ________

Professional Information:

ADA Member? ☐ Yes ☐ No

Are you a member of any of the following organizations: (Please check all that apply.)

Forum Organizations

☐ AAED ☐ AAFP ☐ AAMP ☐ AES ☐ AP ☐ APS ☐ AO

☐ GNYAP ☐ IAG ☐ NADL ☐ NGS ☐ PCSP ☐ SEAP ☐ AAID ☐ NBC

Dental Specialty Groups: (Please check all that apply.)

☐ AAE ☐ AAO ☐ AAOMP ☐ AAOMR ☐ AAOMS ☐ AAP ☐ AAPD ☐ AAPHD

Program Director Verification (to be completed and signed by the Graduate Program Director as verification of information)

____
Institution Attending

____
Institution's City & State

____
Program Attending Expected Completion Date

____________________ ____________________ ____________
Print Program Director's Name Program Director's Signature Date

Applicant's Verification

I hereby certify that the information on this application is correct.

Applicant's Signature: ____ Date: ______________

Qualifications for Student Membership

Students shall be enrolled in an advanced training program in prosthodontics, accredited by the Commission on Dental Accreditation of the American Dental Association or be College members who return to school as full-time students in an accredited institution of higher learning and who elect to apply for this category of membership.

An individual may retain Student Member status until termination of his/her formal training in prosthodontics or until their Student Membership status has reached six years.

Student Members pay a discounted annual session and continuing education course registration fees, and enjoy all member benefits, however, they may not hold voting membership on committees, nor may they hold elective or appointive office.

2009 Student Membership dues is currently being paid for by a grant from the American College of Prosthodontists Education Foundation

Mail or fax your completed application and required documentation 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

For questions, please e-mail Carla Baker, Associate Executive Director at:
cbaker@prosthodontics.org