ACADEMIC ALLIANCE AFFILIATE APPLICATION

AMERICAN COLLEGE OF PROSTHODONTISTS
Your smile. Our specialty.®

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

APPLICANT INFORMATION

First Name | Middle Initial | Last Name

Date of Birth

Gender: ☐ Male ☐ Female

UNIVERSITY/INSTITUTION INFORMATION

☐ Preferred Mailing/Billing Address (Please choose only one)

University/Institution Name

Address Line 1

Address Line 2

Address Line 3

City | State | Zip | Country

Phone | Fax

Email (required for communication purposes) | Website

SECONDARY OFFICE INFORMATION

☐ Preferred Mailing/Billing Address (Please choose only one)

Company/Institution Name

Address Line 1

Address Line 2

Address Line 3

City | State | Zip | Country

Phone | Fax

Email (required for communication purposes) | Website

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HOME INFORMATION

☐ Preferred Mailing/Billing Address (Please choose only one)

Address Line 1

Address Line 2

Address Line 3

City | State | Zip | Country

Home Phone | Cell Phone

Email (required for communication purposes)

APPLICANT EDUCATION

Degrees Earned (Check all that apply): ☐ DDS ☐ DMD ☐ DVM ☐ BDS ☐ PhD ☐ MS ☐ MA ☐ MSD ☐ MPH

Additional degrees not listed above: _____

Dental School Attended | State | Country | Graduation Date

Additional Training Program | State | Country | Graduation Date

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: _____ Percent of Time Teaching Undergraduate: _____

☐ I am the Prosthodontic Department Chair

Postdoctoral Faculty Position/Title: _____

Institution: _____ Percent of Time Teaching Postdoctoral: _____

☐ I am the Prosthodontic Program Director ☐ I am the Maxillofacial Program Director

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ACP MEMBERSHIP DIRECTORY / FIND A COLLEAGUE ONLINE LISTING

☐ Publish my ***Name Only*** in the Membership Directory and Find a Colleague online listing. By checking this box, you are asking that ALL contact information be withheld from the ACP Membership Directory and Find a Colleague listing. ***Only your name*** will appear.

OR Choose any combination from the following options. Please **check all contact data** you wish to have printed in the ACP Membership Directory and Find a Colleague online listing:

☐ Print ***University/Institution Address*** (includes complete University/Institution contact information)

☐ Print ***Secondary Office Address*** (includes complete Secondary Office contact information)

☐ Print ***Home Address*** (includes complete Home contact information)

☐ Print ***Spouse/Companion's Name*** _____
Spouse/Companion Name

APPLICANT VERIFICATION

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

_____ _____
Applicant Signature (Typing your name will serve as your electronic signature) Date

QUALIFICATIONS

Academic Alliance affiliation in the College shall be limited to those individuals who have NOT completed an advanced dental education program in prosthodontics accredited by the Commission on Dental Accreditation of the American Dental Association. These individuals whose credentials include a DDS, DMD, or PhD and who currently hold an academic teaching appointment within an ADA accredited prosthodontic program or an undergraduate teaching position in the discipline of prosthodontics may apply. Applicant must be an instructor spending a *minimum of 50%* of their time teaching as defined by the institution. (Applicants with special circumstances outside of the qualifications outlined for membership may request a special action of the Board of Directors.)

By signing this application, the applicant acknowledges that they are responsible for notifying the College immediately if their teaching appointment/position drops below the minimum 50% teaching requirement. Your information will be presented to the Board of Directors for review and possible status change at the next Board of Directors' Meeting. Failure to notify the ACP when the Academic Alliance affiliates' teaching position falls below the 50% teaching requirement may result in revocation of Alliance status.

FOR CONSIDERATION...

The following must accompany your application:

1. Application and/or reinstatement fee: $125 non-refundable.
2. Dues: Annual affiliate dues are $617 per calendar year.
3. A letter of endorsement from an active ACP member.
4. A letter of verification of the applicant's teaching position from the department chair or dean.

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MEMBERSHIP SERVICES DEPARTMENT CONTACT INFORMATION

MAIL	FAX	PHONE	EMAIL
American College of Prosthodontists 5198 Eagle Way Chicago, IL 60678-5198	(312) 573-1257	(312) 573-1260	acp@prosthodontics.org

PAYMENT

☐ MasterCard ☐ VISA ☐ American Express ☐ Check Enclosed (Check #): _____

_____
Cardholder Name

_____
Credit Card Number Exp. Date

Mail or fax your completed application, payment, and letters to:
American College of Prosthodontists
211 E. Chicago Avenue, Suite 1000
Chicago, IL 60611
Phone: (312) 573-1260 | Fax: (312) 573-1257
Prosthodontics.org
acp@prosthodontics.org