

GLOBAL ALLIANCE AFFILIATE APPLICATION



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

PRIMARY 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

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

Prosthodontic Certificate Program

State

Country

Graduation Date

PRIMARY ACTIVITY

Private Practice Federal Services Education Research

SECONDARY ACTIVITY

Private Practice Education Administration Consultant Hospital Dentist Public Health Research

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 **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)
- 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

Global Alliance affiliation in the College shall be limited to those individuals who have completed an advanced dental education program in prosthodontics which has not been accredited by the Commission on Dental Accreditation of the American Dental Association and whose permanent residence is outside of the United States.

FOR CONSIDERATION...

The following **must** accompany your application:

1. Application and/or reinstatement fee: \$125 non-refundable.
2. Dues: Annual affiliate dues are \$602 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.

PAYMENT

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

Cardholder Name

Credit Card Number

Exp. Date

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