MEMBERSHIP APPLICATION

AMERICAN COLLEGE OF PROSTHODONTISTS
Your smile. Our specialty.®

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

APPLICANT INFORMATION

I am applying as a (check one): ☐ Member ☐ Fellow Gender: ☐ Male ☐ Female

First Name | Middle Initial | Last Name

Date of Birth

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 ☐ 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

Maxillofacial Certificate Program | State | Country | Graduation Date

Are you board-certified by the American Board of Prosthodontics? ☐ YES ☐ NO

Date Certified: _____

PRIMARY ACTIVITY

☐ Private Practice ☐ Federal Services ☐ Education ☐ Research

SECONDARY ACTIVITY

☐ Private Practice ☐ Education ☐ Administration ☐ Consultant ☐ Hospital Dentist ☐ Public Health ☐ Research

PROCEDURES

Check all procedures that you perform in your office: ☐ Bridges ☐ Caps/Crowns ☐ Cleft Palate/Obturator

☐ Congenital/Developmental Mouth Defects ☐ Dental Implants ☐ Dentures ☐ Digital Dentistry and Technology

☐ Esthetic/Cosmetic Dentistry ☐ Pre-prosthetic Surgery ☐ Removable/Partial Dentures ☐ Sleep Apnea

☐ Surgical Placement of Dental Implants ☐ Teeth Grinding/Night Guards ☐ Teeth Whitening ☐ TMJ ☐ Veneers

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PROFESSIONAL INFORMATION

Are you currently an ADA member? ☐ YES ☐ NO

What other professional organizations are you a part 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

FIND A PROSTHODONTIST

All members' office contact information is included in the ACP referral search "Find a Prosthodontist" for consumers, patients, and dental professionals **unless** a member requests to be excluded by checking the box below. This is an important marketing tool for your practice.

☐ I DO NOT wish to be included in the ACP "Find A Prosthodontist" patient referral website

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

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QUALIFICATIONS

Active membership in the College shall be limited to those individuals who have completed an advanced dental education program in prosthodontics accredited by the Commission on Dental Accreditation of the American Dental Association.

Active fellowship in the College shall be limited to those individuals who meet the qualifications for active membership, who are also current Diplomates of the American Board of Prosthodontics.

Residents/graduate students enrolled in accredited advanced dental education programs in prosthodontics should not complete this form. Contact the American College of Prosthodontists Central Office for a Resident/Graduate Student membership application.

FOR CONSIDERATION...

The following must accompany your application:

1. Application and/or reinstatement fee: $125 non-refundable.
2. Dues: Annual membership dues are $866 per calendar year.
3. International Members should contact the ACP Central Office for International Membership Dues rates.
4. Copy of your certificate indicating that you have successfully completed an advanced dental education program in prosthodontics. The program must have been accredited by the Commission on Dental Accreditation at the time you completed your program.
5. Copy of your maxillofacial program certificate if applicable.
6. If you are applying for status as a Fellow, you must include proof of current Diplomate status in the American Board of Prosthodontics.

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
acp@prosthodontics.org