RESIDENT 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

First Name | Middle Initial | Last Name

Date of Birth | Gender: ☐ Male ☐ Female

UNIVERSITY/INSTITUTION INFORMATION

University/Institution Name

Address Line 1

Address Line 2

Address Line 3

City | State | Zip | Country

Phone | Fax

Email (required for communication purposes) | Website

HOME INFORMATION

*Required for all resident applications

Address Line 1

Address Line 2

Address Line 3

City | State | Zip | Country

Home Phone | Cell Phone

Email (required for communication purposes)

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APPLICANT EDUCATION

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

Additional degrees not listed above: _____

Dental School Attended	State	Country	Graduation Date

Prosthodontic Certificate Program	State	Country	Expected Year of Graduation

PROFESSIONAL INFORMATION

Are you currently an ADA member? ☐ YES ☐ NO

What other professional organizations are you a part of? _____

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 ***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 (Please print out, sign, and scan this page) _____ Date _____

PROGRAM DIRECTOR VERIFICATION

To be signed by the Graduate Program Director as verification of information.

Program Director Signature (Please print out, sign, and scan this page) _____ Date _____

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QUALIFICATIONS

Resident membership in the College shall be limited to those individuals who are enrolled in an advanced training program in prosthodontics, accredited by 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 Resident Member status until termination of his/her formal training in prosthodontics or until their resident membership status has reached six years.

Resident Members pay discounted registration fees for Annual Session and continuing education courses and enjoy full member benefits, including the right to vote in ACP elections and participate on ACP committees. However, Resident Members are not allowed to hold elective or appointive office.

SUPPORT

The American College of Prosthodontists supports prosthodontic residents' educational benefits. For a full listing of member benefits provided by the College through this generous support program, please contact the ACP Membership Department at (312) 573-1260 or acp@prosthodontics.org.

Email, mail, or fax your completed application 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