

# AMERICAN PROSTHODONTIC SOCIETY

737 N. Michigan Avenue, Suite 2100, Chicago, IL 60611

Phone: 312.981.6780 Fax: 312.981.6787

## 2009 MEMBERSHIP APPLICATION

**I am applying for APS Membership as** (all fees include mandatory JPD subscription except Graduate Student and Life Member):

- |  |  |
|--|--|
| <input type="checkbox"/> Active Practicing Dentist (USA) <b>\$474.00</b> | <input type="checkbox"/> Active Practicing Dentist (International including Canada) <b>\$535.00</b>  |
| <input type="checkbox"/> Active Dental Tech CDT (USA) <b>\$315.00</b>    | <input type="checkbox"/> Active Dental Tech CDT (International including Canada) <b>\$376.00</b>   |
| <input type="checkbox"/> Graduate Student (Current) – <b>No Fee</b>      | <input type="checkbox"/> Recent Graduate Active (within 5 years) – 3 Year Graduated Reduced Dues Schedule -1 <sup>st</sup> year <b>\$254</b> |
| <input type="checkbox"/> Active Life Member (USA) – <b>\$291.50</b>      | <input type="checkbox"/> Life Member – <b>No Fee</b>   |

(Please Type or Print Clearly)

Date of Application: \_\_\_\_\_

1. Name: \_\_\_\_\_  
(Last) (First) (Middle Initial) (Credential DDS/DMD/CDT, ETC.)
- Mailing Address: \_\_\_\_\_
- City, State, Zip: \_\_\_\_\_
- Phone: \_\_\_\_\_  
(Work) (Home) (Cell)
- Fax: \_\_\_\_\_ Email: \_\_\_\_\_

2. Date of Birth: \_\_\_\_\_ Please check one:  Male  Female

### #s 3-8: For Active Dental Membership Applicants Only

3. Dental Degree from: \_\_\_\_\_ Year: \_\_\_\_\_
4. Other degrees from: \_\_\_\_\_ Year: \_\_\_\_\_
5. Certificates or additional specialty training (please specify): \_\_\_\_\_
6. Type of Practice (please circle): General Prosthodontics Military Hospital Education Other: \_\_\_\_\_
7. ADA Member? Yes/No ADA # \_\_\_\_\_ Are you a member of another national Dental Association? Yes/No
8. Board Certified: Yes/No or Board Eligible: Yes/No \_\_\_\_\_  
(Other national/international dental association name)

### #s 9-10: For Active Dental Technician Membership Applicants Only:

9. Training/School: \_\_\_\_\_ Year of Graduation: \_\_\_\_\_  
Certified Dental Technician Number: \_\_\_\_\_ Date Certified: \_\_\_\_\_  
Specialty(ies) Certified:  Crown & Bridge  Complete Dentures  Removable Partial Dentures  Ceramics
10. Current Employment:  
 Owner/Manager, Commercial Dental Laboratory  Dental Technology Educator  
 Employed technician, Commercial Dental Laboratory  Government Technician  
 Technician, Private Dental Office  Other: \_\_\_\_\_  
(describe)

### #11: For Active Applicants Only:

NOMINATION BY APS MEMBER: (If applicant is not closely related with a member, Central Office will be of assistance.)

11. \_\_\_\_\_  
(Name of member) (Address) (Phone) (Signature) (Date)

### #s 12-15: For Graduate Student Applicants Only:

12. Dental degree from (School): \_\_\_\_\_ Month/Year: \_\_\_\_\_
13. Month/Year of (scheduled) completion of Graduate Program: \_\_\_\_\_
14. Type of Program:  General  Prosthodontics  Implants  Periodontics  Other: \_\_\_\_\_
15. Please list name, complete address (e-mail if available) of Program Director from whom a letter of recommendation will be sent:  
\_\_\_\_\_  
(Name-Program Director) (School) (Address) (City/State/Zip) (Email)

16. If elected to membership in the American Prosthodontic Society, I agree to abide by the Bylaws of the Society.

Signature of Applicant: \_\_\_\_\_ Date: \_\_\_\_\_

### **METHOD OF PAYMENT:**

BY CHECK: Please make check payable to the American Prosthodontic Society in US funds and mail to: **APS, P.O. Box 95198, Palatine, IL 60095-0198**

BY CREDIT CARD: Check one of the following, and fax to: **(312) 981-6787**  MasterCard  VISA  AMEX  Discover

Cardholder Name: \_\_\_\_\_ Billing Address for Card: \_\_\_\_\_

Card Number: \_\_\_\_\_ Expires: \_\_\_\_\_ CCV Code: \_\_\_\_\_ Signature: \_\_\_\_\_