

**The American Academy
of
Fixed Prosthodontics**

MEMBERSHIP APPLICATION

(Must be typed. Complete all information.)

(An incomplete application will be returned and delay activation of membership.)

STEP ONE: PERSONAL INFORMATION

LAST NAME _____ FIRST NAME _____ PREFERRED NAME _____

DATE OF BIRTH _____ CITIZENSHIP _____ GENDER: M F

HOME INFORMATION **PREFERRED MAILING/BILLING ADDRESS**

ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____ - _____ Country _____

FAX _____ E-MAIL _____ PHONE _____

PRIMARY OFFICE INFORMATION **PREFERRED MAILING/BILLING ADDRESS**

PRACTICE NAME / INSTITUTION / COMPANY _____

ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____ - _____ Country _____

FAX _____ E-MAIL _____ PHONE _____

SECONDARY OFFICE INFORMATION **PREFERRED MAILING/BILLING ADDRESS**

PRACTICE NAME / INSTITUTION / COMPANY _____

ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____ - _____ Country _____

FAX _____ E-MAIL _____ PHONE _____

STEP TWO: AAFP MEMBERSHIP DIRECTORY WEB/SITE LISTING

Choose any one of the following options:

(Directory Website listings are located in password-protected members-only pages)

- Print Home Address
(Includes: address, telephone, fax, & email information for Home)

- Print Primary Office Address
(Includes: address, telephone, fax, & email for Primary Office)
- Print Secondary Office Address
(Includes: address, telephone, fax, & email information for Secondary Office)

STEP THREE: EDUCATIONAL INFORMATION

Degrees earned (check all that apply):

- DDS DMD MSD PhD MS MA BS BA

DENTAL SCHOOL ATTENDED CITY STATE COUNTRY YEAR OF GRADUATION

GPR/AEGD TRAINING PROGRAM CITY STATE COUNTRY YEAR OF GRADUATION

SPECIALTY TRAINING PROGRAM CITY STATE COUNTRY YEAR OF COMPLETION

Specialty Training Program:

- PROSTHODONTICS OTHER _____

Is the candidate certified by the American Board of Prosthodontics? Yes___ No___

Year certified:_____ Board Eligible_____ Educationally Qualified_____ Recertification Date:_____

Is the candidate certified by another ADA recognized specialty? Yes___ No___

Year certified: _____ Board Eligible_____ Educationally Qualified_____ Recertification Date:_____

STEP FOUR: PROFESSIONAL INFORMATION

Provide ADA Membership Number or International Equivalent, if applicable _____

Professional Activity (check all that apply with appropriate percentages)

- Private Practice (PP) _____% Military (MT) _____% Veterans Administration (VA) _____%
- Public Health (PH) _____% Education (ED) _____% Administration (AD) _____%
- Consultant (CN) _____% Hospital Dentist (HD) _____% Retired (RD) _____%

Areas of Interest (check all that apply and place appropriate percentage of your total practice.)

- Complete Dentures _____% Removable Partial Dentures _____%
- Tooth Supported Fixed Partial Dentures _____% Maxillofacial Prosthetics _____%
- Temporomandibular Disorders _____% Fixed Implant Prostheses _____%
- Implant Supported/Retained Removable Prostheses _____%

PROFESSIONAL MEMBERSHIPS/ ACTIVITIES		
Organization	Positions Held/Committee Service	Inclusive Dates

FACULTY APPOINTMENTS			
Institution	Inclusive Dates	Academic Rank	Hours per Week

LECTURES, PROFESSIONAL PRESENTATIONS AND COURSES <u>GIVEN</u> (last two years only)		
Title or Subject	Organization and Location	Inclusive Date, Hours

CONTINUING EDUCATION COURSES <u>TAKEN</u> (last two years only)		
Name of Course and Instructor	Location - Sponsor	Dates Attended-Year

SCIENTIFIC ARTICLES PUBLISHED		
Title	Publication	Date

If additional space is required for any items listed above, please attach additional pages as needed.

