

**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.

**GUEST ATTENDANCE:**

*Year or years which the nominee was a guest, essayist, or clinician of the Academy (AAFP):*

\_\_\_\_\_

**CONFIDENTIAL INFORMATION:**

Has the nominee ever been censured by any component of organized dentistry?

YES     NO

If the answer to the above is yes, explain the circumstances in a separate enclosure. The information contained therein will be available only to the Credentials Committee for their use during deliberations and will be held in the strictest confidence.

*TO THE SPONSOR:*

I have read the criteria for membership contained in this nomination, and do hereby certify that, to the best of my knowledge, the contents are true and factual. I have known the nominee for \_\_\_\_\_ years and have known him/her to be an honest and trustworthy member of the dental profession and worthy of Membership in the American Academy of Fixed Prosthodontics. **The sponsor and co-sponsor must have first hand knowledge of the candidate. The sponsor must submit the completed application along with a written evaluation of the candidate's credentials.**

**CANDIDATE**

**SIGNATURE** \_\_\_\_\_

**TYPED NAME** \_\_\_\_\_ **DATE** \_\_\_\_\_

**PHONE** \_\_\_\_\_ **EMAIL** \_\_\_\_\_

**PRIMARY SPONSOR**

**SIGNATURE** \_\_\_\_\_

**TYPED NAME** \_\_\_\_\_ **DATE** \_\_\_\_\_

**PHONE** \_\_\_\_\_ **EMAIL** \_\_\_\_\_

**CO-SPONSOR**

**SIGNATURE** \_\_\_\_\_

**TYPED NAME** \_\_\_\_\_ **DATE** \_\_\_\_\_

**PHONE** \_\_\_\_\_ **EMAIL** \_\_\_\_\_

**MAKE SURE THE FOLLOWING IS ENCLOSED:**

- \$175.00 Application Fee
- \$350.00 Guest Registration Fee
- One Letter from Primary Sponsor