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 _____%

(COPIES OF THIS PAGE CAN BE ADDED AS REQUIRED)

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 GIVEN (last two years only)		
Title or Subject	**Organization and Location**	**Inclusive Date, Hours**

CONTINUING EDUCATION COURSES TAKEN (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 COMPLETED:

☐ $795.00 Application and Meeting Registration Fees (TO BE PAID ONLINE ON OR AFTER OCTOBER 1ST)
☐ One Letter from Primary Sponsor