

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 Protheses _____%

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:

- \$835.00 Application and Meeting Registration Fees (TO BE PAID [ONLINE](#) ON OR AFTER OCTOBER 1ST)
- One Letter from Primary Sponsor