



2010 GENERAL MEMBERSHIP APPLICATION

For more information:
Call us toll-free: **888.AGD.DENT (888.243.3368)**
Or join online: www.agd.org

Code: _____

Referral Information

If you were referred to the AGD by a current member, please note information below:

Member's Name _____

City, State, Province or Federal Services Branch _____

Member Information

First Name	MI	Last Name	Designation (e.g. DDS, DMD, BDS)	Informal Name (If applicable)
Type of Membership: (Check one) <input type="checkbox"/> Active General Dentist <input type="checkbox"/> Active General Dentist (Recent graduate in last four years) <input type="checkbox"/> Associate <input type="checkbox"/> Resident <input type="checkbox"/> Dental Student <input type="checkbox"/> Affiliate				<input type="text"/> / <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Date of Birth (mm/dd/yyyy) Required for access to the AGD Web site
Do you currently hold a valid U.S./Canadian dental license? <input type="checkbox"/> Yes <input type="checkbox"/> No				
		License Number _____	State/Province _____	Date Received (mm/yyyy) _____
If you are not in general practice, please indicate your specialty: _____				
Current practice environment: (Check one) <input type="checkbox"/> Solo <input type="checkbox"/> Associateship <input type="checkbox"/> Group Practice <input type="checkbox"/> Hospital <input type="checkbox"/> Resident <input type="checkbox"/> Faculty: _____ Institution <input type="checkbox"/> Federal Services: _____ Branch				
If you are a member of the Canadian Forces Dental Service, please indicate your preferred constituent: <input type="checkbox"/> U.S. Military Counterpart <input type="checkbox"/> Local Canadian Constituent				

Contact Information

Your AGD constituent is determined by your business address, unless one is not available.

PREFERRED METHOD OF CONTACT:

E-mail Mail Phone

PREFERRED BILLING/MAILING ADDRESS:

Business Home

Business Address	City	State/Province	ZIP/Postal Code
Name of Business (If applicable)	Phone	Fax	
Home Address	City	State/Province	ZIP/Postal Code
Phone	Primary E-mail	Web site Address	

Education Information

ARE YOU A GRADUATE OF AN ACCREDITED* U.S./CANADIAN DENTAL SCHOOL? Yes No Currently Enrolled

Dental School	Graduation Date (mm/yyyy)		
_____	<input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>		
Are you a graduate of an accredited* U.S. or Canadian post-doctoral program? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Currently Enrolled			
TYPE: <input type="checkbox"/> AEGD <input type="checkbox"/> GPR <input type="checkbox"/> Other *See back.			
Post-Doctoral Institution	State/Province	Begin Date (mm/dd/yyyy)	End Date (mm/dd/yyyy)
_____	_____	_____	_____

Optional Information

GENDER: Male Female Are you interested in becoming: A Mentor A Mentee

ETHNICITY: American Indian Asian African-American Hispanic Caucasian Other _____

HOW DID YOU HEAR ABOUT US? AGD Member (please indicate information in the Referral Information box) AGD Web site AGD Constituent
 Newsletter Advertisement Mailing Dental Meeting Other _____

Dues Information

Refer to back side for membership and constituent dues rates.

1 AGD Membership Dues

2 Florida AGD Dues

+ \$70.00

TOTAL AMOUNT ENCLOSED (Required) = _____

Return this application with your payment to:

Academy of General Dentistry
211 East Chicago Avenue, Suite 900
Chicago, IL 60611-1999

For credit card payments, fax to: 312.335.3443

Dues rates effective until 10/01/10. Contact the AGD or visit www.agd.org for updated rates.

Payment Information

Promotional Code (If applicable) _____

Check (Enclosed) VISA MasterCard American Express Diners Club Discover

NOTE: Payments for Canadian members can only be accepted via VISA, MasterCard, or check.

Exp. _____

Please print the name as it appears on the card

I hereby certify that all the information I have provided on this application is correct, and by remitting dues to the AGD, I agree to all terms of membership.

Signature _____

Date _____