



2010 STUDENT 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 _____ (Preferred Name) _____
Date of Birth (mm/dd/yyyy) / /

Contact Information

PREFERRED METHOD OF CONTACT: E-mail Mail Phone

Primary Street Address _____
City _____ State/Province _____ ZIP/Postal Code _____ Phone _____
Primary E-mail _____ Alternative E-mail _____

Education Information

ARE YOU CURRENTLY ENROLLED IN AN ACCREDITED* U.S./CANADIAN DENTAL SCHOOL? Yes No

Dental School (Constituent is based on location of dental school) _____ Anticipated Graduation Date (mm/yyyy) _____
ARE YOU PLANNING TO ENROLL IN AN ACCREDITED* U.S./CANADIAN POST-DOCTORAL PROGRAM? Yes No Undecided
TYPE: AEGD GPR Other _____
Post-Doctoral Institution _____ State/Province _____ Begin Date (mm/dd/yyyy) _____ End Date (mm/dd/yyyy) _____

**Official accreditation is given by the Council on Dental Accreditation (CODA) in the U.S. and the Council on Dental Accreditation in Canada (CDAC) for all Canadian provinces.*

Optional Information

GENDER: Male Female ETHNICITY: American Indian Asian African-American Hispanic Caucasian Other
ARE YOU INTERESTED IN BECOMING A MENTEE: Yes No Undecided
HOW DID YOU HEAR ABOUT US? AGD Member (Please indicate name in the Referral Information box) AGD Web site Search Engine
 Newsletter Advertisement Mailing Dental Meeting Other _____

Payment Information

PROMOTIONAL CODE _____
TOTAL AMOUNT ENCLOSED **\$16**

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 _____

Return this application with your payment to:
Academy of General Dentistry
211 East Chicago Avenue, Suite 900
Chicago, IL 60611-1999

For applicants paying with credit cards fax to:
312.335.3443.

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