



2009 GENERAL MEMBERSHIP APPLICATION

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

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 (i.e. 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 _____	

Educational Information

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

Dental School _____ **Graduation Date** (mm/yyyy) /

Are you a graduate of an accredited* U.S. or Canadian post-doctoral program? Yes No Currently Enrolled

Post-doctoral Institution _____ **Begin Date** (mm/dd/yyyy) _____ **to** _____ **End Date** (mm/dd/yyyy) _____

For information on qualifying for the residency dues discount, please refer to the description on the back.

Optional Information

GENDER Male Female

ETHNICITY American Indian Asian African-American Hispanic Caucasian Other _____

HOW DID YOU HEAR ABOUT US? AGD Member (please indicate information in the referral 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) = _____

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, 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 credit card payments, fax to: 312.335.3443
Dues rates effective until 10/01/09. Contact the AGD or visit www.agd.org for updated rates.