



American Academy of Implant Dentistry Membership Acceptance Form

PERSONAL INFORMATION

Name _____

Office Address _____

City _____ State _____ Zip _____ Country _____

Office Telephone _____ Office Fax _____ Year of birth _____

E-Mail _____ Website _____

Dental Education: _____ Degree _____ Year _____

Advanced Dental Education: _____ Degree _____ Year _____

Are you currently enrolled as a full-time student in an undergraduate or graduate dental program?

No Yes If yes, specify the institution/hospital _____

Type of program _____ Completion date _____

Area of Practice: General Oral Surgery Periodontics Prosthodontics

Other (specify) _____

How did you learn about the AAID? Member referral (specify) _____

Internet Direct mail Publication Other _____

Membership Dues AAID's membership year is December 1 - November 30, and the annual dues are \$295 for general members, and \$50 for student/resident members, who must provide documentation of enrollment as a full-time student. For those joining between July 1 and November 30, the dues are \$175 for general members and \$25 for students/residents.

Payment My check for \$ _____, payable to the AAID in US dollars, is enclosed.

Please charge \$ _____ to my _____ VISA _____ MasterCard

Account Number _____ Sec Code _____ Exp. Date _____

Cardholder's Name _____

Submit your application and payment to :

Mail: American Academy of Implant Dentistry
c/o Delaware Place Bank, Dept. 350
190 E. Delaware Place, Dept. #350
Chicago, IL 60611

Fax: 312.335.9090

Communications by fax I would like the AAID and the AAID Research Foundation to send me facsimiles, including professional news and information, meeting and continuing education course information, and other promotional materials, so I can take full advantage of the various programs and services offered by the AAID. Yes No

List all fax numbers that can be used to provide you with the latest AAID information:

Please acknowledge your consent by signing below.

Signature _____ Date _____