



# 2010 GENERAL MEMBERSHIP APPLICATION

For more information:  
Call us toll-free: **888.AGD.DENT (888.243.3368)**  
Or join online: [www.agd.org](http://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 \_\_\_\_\_

## Your Information

First Name \_\_\_\_\_ MI \_\_\_\_\_ Last Name \_\_\_\_\_ (Preferred Name) \_\_\_\_\_ Date of Birth (mm/dd/yyyy) \_\_\_\_\_  
Required for access to the members-only AGD Web site

**PREFERRED MAILING ADDRESS**  Professional  Home *(Your AGD constituent is determined by your professional address, unless one is not available.)*

**GENDER**  Male  Female    **ETHNICITY (Optional)**  American Indian  Asian  African-American  Hispanic  Caucasian  Other

**HOW DID YOU HEAR ABOUT US?**  AGD Member (please indicate name and constituent in the above box)  AGD Web site  AGD Constituent  Newsletter

Advertisement  Mailing  Dental Meeting  Other \_\_\_\_\_

**AGD Privacy Information**  
The AGD has systems and procedures in place to protect your privacy in relation to the handling of your personal information. The AGD does not collect personal information unless it is necessary to performing one or more of its functions and activities. On occasion, the AGD may collect personal information, but only with your consent or when required to by law. For more information, please visit [www.agd.org](http://www.agd.org), or contact the Membership Services Center at 888.AGD.DENT (888.243.3368).

## Professional Information

**NAME OF BUSINESS (if applicable)** \_\_\_\_\_ **Web site** \_\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_ Province \_\_\_\_\_ ZIP \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_ E-mail \_\_\_\_\_

**DO YOU HAVE A VALID U.S./CANADIAN DENTAL LICENSE?**  Yes  No Date Received (mm/dd/yyyy) \_\_\_\_\_ License # \_\_\_\_\_

If you are not in general practice, what is your specialty? \_\_\_\_\_

Which best describes your current practice environment? (Check one)  Solo  Associateship  Group Practice  Hospital  Resident  Other \_\_\_\_\_

Faculty \_\_\_\_\_ Please Indicate Institution \_\_\_\_\_  Federal Services \_\_\_\_\_ Please Indicate Branch \_\_\_\_\_

## Home Address

Street Address \_\_\_\_\_ City \_\_\_\_\_ Province \_\_\_\_\_ ZIP \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_ E-mail \_\_\_\_\_

## Educational Profile

Dental School \_\_\_\_\_ Degree Obtained  DDS  DMD  BDS  Other \_\_\_\_\_

Graduation Date (mm/yyyy) \_\_\_\_\_ Are you a graduate of (or resident in) an accredited U.S. or Canadian post-doctoral program?  Yes  No

Post-doctoral Institution \_\_\_\_\_ Begin Date (mm/dd/yyyy) \_\_\_\_\_ End Date (mm/dd/yyyy) \_\_\_\_\_

### 2010 AGD Headquarter Dues

- All amounts in Canadian dollars.  
Please check membership type applying for:
- Active General Dentist .....\$342.00
  - Associates (Specialists).....\$342.00
  - Dental Students\* .....\$16.00  
\*Students do not pay AGD Constituent dues.
  - 1st Year Graduate/  
Current Resident.....\$69.00
  - 2nd Year Grad.....\$137.00
  - 3rd Year Grad.....\$206.00
  - 4th Year Grad.....\$274.00
  - Affiliate.....\$171.00

AGD Headquarter Dues (See above rates) ..... \_\_\_\_\_

British Columbia Constituent Dues (See above rates) ..... \_\_\_\_\_

**Total Amount Enclosed:** ..... \_\_\_\_\_

Individuals joining 7/1-9/30 pay half the annual headquarters membership dues. (Does not apply to student, resident, or recent graduate members). Individuals joining 10/1-12/31/10 enjoy membership through the end of 2011. Paid dues will be applied to the upcoming year.

### 2010 British Columbia AGD Constituent Dues

- Please check membership type applying for:
- 1st Year Graduate/
  - Current Resident.....\$30.00
  - 2nd Year Grad.....\$30.00
  - 3rd Year Grad.....\$30.00
  - 4th Year Grad.....\$30.00
  - Regular Active/Associates .....\$30.00

### Payment

- Check (Enclosed)  
 VISA  MasterCard

\_\_\_\_\_

Expiration Date

I hereby certify that all of the above information is correct, and that by signing this application agree to all terms of membership including completion of 75 hours of continuing education every three years for Active General Dentist and Associate Members.

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