



2010 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 _____

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, 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 _____ State _____ 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 _____ State _____ 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

- Please check membership type applying for:*
- Active General Dentist\$347.00
 - Associates (Specialists).....\$347.00
 - Dental Students*\$16.00
 - *Students do not pay AGD Constituent dues.*
 - 1st Year Graduate/Current Resident.....\$70.00
 - 2nd Year Grad.....\$139.00
 - 3rd Year Grad.....\$208.00
 - 4th Year Grad.....\$278.00
 - Affiliate.....\$174.00

2010 California AGD Constituent Dues

- Please check membership type applying for:*
- 1st Year Graduate/Current Resident.....\$5.00
 - 2nd Year Grad.....\$95.00
 - 3rd Year Grad.....\$95.00
 - 4th Year Grad.....\$95.00
 - Regular Active/Associates\$95.00

AGD Headquarter Dues (See above rates) _____

California 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 first year 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.

Per the Revenue Reconciliation Act of 1993, 1.2% of membership dues payment is allocable to the AGD's lobbying activities and is not deductible as a business expense. Please consult with your financial advisor for detailed information.

Payment

- Check (Enclosed)
 VISA MasterCard American Express Diners Club Discover

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