



Academy
of General Dentistry

Lifelong Learning & Service Recognition Application

(Application must be postmarked by March 31, 2010)

PLEASE PRINT

AGD ID# _____ Date of Membership _____

First Name _____ Middle Initial _____ Last Name _____ Degree _____

Address _____

City _____ State/Province _____ ZIP Code _____

Phone _____ Cell _____

Fax# _____ E-mail address _____

State Licensed In _____ License # _____ Military Branch (If applicable) _____

Payment

My check # _____ in the amount of \$500, payable to AGD in U.S. dollars, is enclosed (\$25 fee for all returned checks)

Or charge my ()VISA ()MasterCard

Credit card number _____

Exp. _____

*CVV2 _____

*CVV2 is an authentication system to protect your transaction from credit fraud.
On Visa and MasterCard the CVV2 number is the final three-digit number in the signature field.

Signature (We cannot process credit card payments without a signature.) _____

Date _____

I affirm that the attached Lifelong Learning & Service Recognition (LLSR) Application accurately itemizes my AGD-acceptable LLSR credits. I understand that the Academy of General Dentistry may check the accuracy of the credits listed. I also understand that I am responsible for the completeness and accuracy of the credit information attached and that the AGD is not responsible for any errors or omissions in my computer record. I agree to abide by the decision of the Dental Education Council regarding whether or not I meet the requirements for LLSR. I do hereby attest that my privilege to practice dentistry has not been suspended or revoked in the past five (5) years, is not currently under consideration for suspension or revocation and that I am currently in good standing with my local State Board of Dentistry. I also attest that I have paid my AGD membership dues and I am currently in good standing with the AGD. I understand that inaccurate information can result in permanent ineligibility to receive the LLSR and that such decisions made by the Dental Education Council are final.

Signature _____

Date _____

IMPORTANT PERSONALIZATION INFORMATION:

This is how I would like my name engraved on crystal:

Please Print

Please note: Submitting this information does not guarantee that your application will be approved by the Dental Education Council.

Mail or Fax Application to:

Academy of General Dentistry- DE

28148 Network Place

Chicago, IL 60673-1281

FAX: 312.335.3428, Attn: DE Department