



American Academy of Implant Prosthodontics

Membership Application—Dentist

PERSONAL

Name: _____ Degree: _____

Office Address: _____

Home Address: _____

Office Phone: _____ Home Phone: _____

Fax: _____ Email: _____

EDUCATION

Dental School	Dates of Attendance	Degree
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Residency Training	Dates of Attendance	Degree/Certificate
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Post-Graduate	Dates of Attendance	Degree/Certificate
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PROFESSIONAL STATUS

Private Practice: Full Time _____ Part Time _____
General Dentistry _____ Specialty _____

Faculty: Full Time_____

Part Time_____

Student: Graduate_____

Undergraduate_____

Military: Active_____

Reserve_____

HOSPITAL ATTENDING STAFF

PROFESSIONAL ASSOCIATION MEMBERSHIPS

PUBLICATIONS

Signature

Date

Please return this form along with the appropriate fee to:

American Academy of Implant Prosthodontics
8672 East Eagle Claw Drive
Scottsdale, AZ 85266-1058 USA