



2017 AGD & British Columbia AGD Membership Application

For more information:
Join online at www.agd.org.
Call us at 888.243.3368 or 312.440.4300.

Promotional code: _____

Referral Information
If you were referred to the AGD by a current member, please note his or her information below:

Member's name _____

City, state/province, or U.S. Federal Services branch _____

Member Information

First name _____ MI _____ Last name _____ Designation (e.g. DDS, DMD, BDS) _____ Date of birth (mm/dd/yyyy) _____
Required for access to the members-only sections of the AGD website

Do you currently hold a valid U.S./Canadian dental license? No Yes: License number _____ State/Province _____ Date renewed (mm/yyyy) _____

Type of membership: (Check one): Active general dentist Associate Resident Dental student Affiliate

If you are not in general practice, please indicate your specialty: _____

Current practice environment: (Check one): Solo Associateship Group practice Hospital Resident Corporate Other _____

Faculty _____ Please indicate institution _____ Federal Services _____ Please indicate branch _____

If you are a member of the Canadian Forces Dental Service, please indicate your preferred constituent: U.S. Military counterpart Local Canadian constituent

Contact Information

Your AGD constituent is determined by your business address, unless one is not available.

Preferred billing/mailling address: Business Home
Preferred method of contact: Email Mail Phone

Business address _____ City _____ State/province _____ ZIP/postal code _____ Country _____

Name of business (If applicable) _____ Phone _____ Fax _____

Home address _____ City _____ State/province _____ ZIP/postal code _____ Country _____

Phone _____ Primary email _____ Website address _____

Educational Information

Are you a graduate of an accredited* U.S./Canadian dental school? Yes No Currently enrolled

Dental school _____ State/province _____ Country _____ Date of graduation (mm/yyyy) _____

Are you a graduate of (or resident in) an accredited** U.S. or Canadian postdoctoral program? Yes No Currently enrolled Type: AEGD GPR Other _____

Postdoctoral institution _____ State/province _____ Country _____ Start date (mm/dd/yyyy) _____ End date (mm/dd/yyyy) _____

Optional Information

Gender Male Female

Ethnicity American Indian Asian African-American Hispanic Caucasian Other _____

Are you interested in becoming one of the following? Mentor Mentee

*Official accreditation is given by CODA in the U.S. and CDAC for all Canadian provinces.

**Accredited dental residencies qualify for the resident membership rate. Official proof of enrollment must be provided to AGD.

AGD Privacy Information

In accordance with the Canadian Personal Information and Electronic Documents Act (PIPEDA), the AGD does not share personal information other than name, preferred address, and phone number for commercial purposes.

2017 AGD Headquarters Dues

All amounts in Canadian dollars.
Please check membership type applying for:

- Active General Dentist\$427
- Associate (Specialist)\$427
- Affiliate.....\$214
- Resident.....\$86
- 2016 Graduate.....\$86
- 2015 Graduate.....\$171
- 2014 Graduate.....\$256
- 2013 Graduate.....\$341
- Dental Student.....\$22
- Active General Dentist\$100
- Associate.....\$100
- Affiliate.....\$0
- 2016 Graduate/
Current Resident.....\$100
- 2015 Graduate\$100
- 2014 Graduate\$100
- 2013 Graduate\$100
- Dental Student\$0

AGD Headquarters Dues: (See above rates) _____

British Columbia Constituent Dues: (See above rates) _____

Total Amount Enclosed: _____

Individuals joining July 1 to Sept. 30, 2017 pay half the annual headquarters membership dues. (Does not apply to student, resident, first-year graduate, or affiliate members). Individuals joining Oct. 1 to Dec. 31, 2016, enjoy membership through the end of 2017. Paid dues will be applied to the upcoming year.

Dues rates effective through Sept. 30, 2017. Contact the AGD or visit www.agd.org for updated rates.

Payment

- Check (Enclosed)
 Visa MasterCard

Note: Payments for Canadian members can only be accepted via VISA, MasterCard, or check.

Expiration date _____ Please print name as it appears on the card.

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,
560 W. Lake St., Sixth Floor, Chicago, IL 60661-6600, USA.
If paying by credit card, fax to 312.335.3443 (secure fax number).