



# CONNECTICUT ACADEMY of GENERAL DENTISTRY

## 2020 AGD Membership Application

Join online at [agd.org](http://agd.org), or 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<br>(e.g. DDS, DMD, BDS) | Primary Email address                           |
| Do you currently hold a valid U.S./Canadian dental license? <input type="checkbox"/> No <input type="checkbox"/> Yes: _____                                                                                                                                           |    |                                                  |                                     |                                                 |
| License number                                                                                                                                                                                                                                                        |    |                                                  | State/province                      | Date renewed (mm/yyyy)                          |
| Type of membership: (Check one.) <input type="checkbox"/> Active general dentist <input type="checkbox"/> Associate (dental specialist) <input type="checkbox"/> Resident <input type="checkbox"/> Dental student <input type="checkbox"/> Affiliate                  |    |                                                  |                                     |                                                 |
| If you are not in general practice, please indicate your specialty: _____                                                                                                                                                                                             |    |                                                  |                                     |                                                 |
| Current dental practice environment: (Check one.) <input type="checkbox"/> Solo <input type="checkbox"/> Associateship <input type="checkbox"/> Group practice <input type="checkbox"/> Hospital <input type="checkbox"/> Resident <input type="checkbox"/> Corporate |    |                                                  |                                     |                                                 |
| <input type="checkbox"/> Other _____                                                                                                                                                                                                                                  |    | <input type="checkbox"/> Full Time Faculty _____ |                                     | <input type="checkbox"/> Federal Services _____ |
|                                                                                                                                                                                                                                                                       |    | Please indicate institution                      |                                     | Please indicate branch                          |
| If you are a member of the Canadian Forces Dental Service, please indicate your preferred constituent:                                                                                                                                                                |    |                                                  |                                     |                                                 |
| <input type="checkbox"/> U.S. military counterpart <input type="checkbox"/> 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 |
| Name of business (if applicable) | Phone             | Fax            |                 |
| Home address                     | City              | State/province | ZIP/postal code |
| Phone                            | Alternative email | Date of Birth  |                 |

### 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?                                                                                                        |                |         |                              |
| <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Currently enrolled Type: <input type="checkbox"/> AEGD <input type="checkbox"/> GPR <input type="checkbox"/> Other |                |         |                              |

\*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.

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

### OPTIONAL INFORMATION

Gender: ☐ Male ☐ Female ☐ Prefer not to disclose  
Ethnicity: ☐ American Indian ☐ Asian ☐ African-American ☐ Hispanic ☐ Caucasian ☐ Other  
I am interested in participating in the AGD Mentor Match Program as a: ☐ Mentor ☐ Mentee

#### 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 perform 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 AGD Membership Services Center at 888.243.3368.

### 2020 AGD

#### Headquarters Dues

Please check membership type applying for:

- |                                                       |       |                                                               |      |
|-------------------------------------------------------|-------|---------------------------------------------------------------|------|
| <input type="checkbox"/> Active General Dentist ..... | \$406 | <input type="checkbox"/> Active General Dentist .....         | \$15 |
| <input type="checkbox"/> Associate (Specialist) ..... | \$406 | <input type="checkbox"/> Associate .....                      | \$15 |
| <input type="checkbox"/> Affiliate .....              | \$203 | <input type="checkbox"/> Affiliate .....                      | \$0  |
| <input type="checkbox"/> Resident .....               | \$81  | <input type="checkbox"/> 2019 Graduate/Current Resident ..... | \$0  |
| <input type="checkbox"/> 2019 Graduate .....          | \$81  | <input type="checkbox"/> 2018 Graduate .....                  | \$15 |
| <input type="checkbox"/> 2018 Graduate .....          | \$162 | <input type="checkbox"/> 2017 Graduate .....                  | \$15 |
| <input type="checkbox"/> 2017 Graduate .....          | \$244 | <input type="checkbox"/> 2016 Graduate .....                  | \$15 |
| <input type="checkbox"/> 2016 Graduate .....          | \$325 | <input type="checkbox"/> Dental Student .....                 | \$0  |
| <input type="checkbox"/> Dental Student .....         | \$20  |                                                               |      |

AGD Headquarters Dues: (See above rates.) ..... \$ \_\_\_\_\_

Connecticut AGD Constituent Dues: (See above rates.) ..... \$ \_\_\_\_\_

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

Individuals joining July 1 to Sept. 30, 2020, 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, 2019, enjoy membership through the end of 2020. Paid dues will be applied to the upcoming year.

Per the U.S. Revenue Reconciliation Act of 1993, 1.2 percent 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 adviser for detailed information.

Dues rates effective through Sept. 30, 2020. Contact the AGD or visit [agd.org](http://agd.org) for updated rates.

### 2020 Connecticut AGD Constituent Dues

I hereby certify that all of the above information is correct, and that by signing this application, I 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 \_\_\_\_\_

**Note:** Check payment is required with hard copy applications. To pay with credit card, please apply online at [agd.org/join-agd](http://agd.org/join-agd). If you have any questions, please contact our Membership Services Center at 888.243.3368.

**Please sign this application and submit payment to:**

Academy of General Dentistry  
560 W. Lake St., Sixth Floor  
Chicago, IL 60661-6600