



RHODE ISLAND ACADEMY of GENERAL DENTISTRY

2022 AGD Membership Application

Join online at 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 (e.g. DDS, DMD, BDS) _____ Primary Email address _____

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 (dental specialist) Resident Dental student Affiliate

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

Current dental practice environment: (Check one.) Solo Associateship Group practice Hospital Resident Corporate

Other _____ Full-Time Faculty _____ Federal Services _____
Please indicate institution _____ Please indicate branch _____

CONTACT INFORMATION

Preferred billing/mailling address: Business Home

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

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

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

Home address _____ City _____ State/province _____ ZIP/postal code _____
Date of Birth _____

Phone _____ Cell phone _____ Alternate email _____

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

*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

2022 AGD Headquarters Dues

Please check membership type applying for:

- | | |
|--|---|
| <input type="checkbox"/> Active General Dentist\$420 | <input type="checkbox"/> Active General Dentist\$20 |
| <input type="checkbox"/> Associate (Specialist)\$420 | <input type="checkbox"/> Associate\$20 |
| <input type="checkbox"/> Affiliate\$210 | <input type="checkbox"/> Affiliate\$0 |
| <input type="checkbox"/> Resident\$21 | <input type="checkbox"/> Resident\$0 |
| <input type="checkbox"/> 2021 Graduate\$84 | <input type="checkbox"/> 2021 Graduate\$20 |
| <input type="checkbox"/> 2020 Graduate\$168 | <input type="checkbox"/> 2020 Graduate\$20 |
| <input type="checkbox"/> 2019 Graduate\$252 | <input type="checkbox"/> 2019 Graduate\$20 |
| <input type="checkbox"/> 2018 Graduate\$336 | <input type="checkbox"/> 2018 Graduate\$20 |
| <input type="checkbox"/> Dental Student\$21 | <input type="checkbox"/> Dental Student\$0 |

1. AGD Headquarters Dues: \$ _____
Upgrade to Premium Plus Membership* (Add \$130 USD) \$.....

2. AGD Constituent Dues: \$ _____

3. AGD Component Dues: \$ _____

Total Amount Enclosed: \$ _____

Student and resident members are not eligible for Premium Plus Membership. Head to agd.org/membership to review a full listing of membership benefits.

Per the U.S. Revenue Reconciliation Act of 1993, .81 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 September 30, 2022 Contact the AGD or visit agd.org for updated rates.

2022 Rhode Island 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/membership. 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
PO BOX 4451
CAROL STREAM, IL 60197-4451