



WEST VIRGINIA

ACADEMY of

GENERAL DENTISTRY

2026 AGD Membership Application

Join online at [agd.org](https://agd.org), or call us at 888.243.3368 or 312.440.4300.

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                          |

CONTACT INFORMATION

Preferred billing/mailing 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 |
| Phone                            | Cell phone | Alternate 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?

☐ 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 ☐ Not listed

Ethnicity: ☐ American Indian ☐ Asian ☐ African-American ☐ Hispanic ☐ Caucasian ☐ Other

I am interested in participating in the AGD Mentor Match Program as a: ☐ Mentor ☐ Mentee

2026 AGD Dues

Please check membership type applying for:

- |                                                         |       |
|---------------------------------------------------------|-------|
| <input type="checkbox"/> Active General Dentistry ..... | \$496 |
| <input type="checkbox"/> Associate (Specialist) .....   | \$496 |
| <input type="checkbox"/> Affiliate .....                | \$248 |
| <input type="checkbox"/> 2025 Graduate .....            | \$99  |
| <input type="checkbox"/> 2024 Graduate .....            | \$198 |
| <input type="checkbox"/> 2023 Graduate .....            | \$298 |
| <input type="checkbox"/> 2022 Graduate .....            | \$397 |
| <input type="checkbox"/> Student/Resident .....         | \$22  |

2026 West Virginia AGD  
Constituent Dues

- |                                                       |      |
|-------------------------------------------------------|------|
| <input type="checkbox"/> Active General Dentist ..... | \$25 |
| <input type="checkbox"/> Associate .....              | \$25 |
| <input type="checkbox"/> Affiliate .....              | \$0  |
| <input type="checkbox"/> 2025 Graduate .....          | \$0  |
| <input type="checkbox"/> 2024 Graduate .....          | \$25 |
| <input type="checkbox"/> 2023 Graduate .....          | \$25 |
| <input type="checkbox"/> 2022 Graduate .....          | \$25 |
| <input type="checkbox"/> Student/Resident .....       | \$0  |

- |                                                           |          |
|-----------------------------------------------------------|----------|
| 1. AGD Dues: .....                                        | \$ _____ |
| Upgrade to Premium Plus Membership* (Add \$199 USD) ..... | \$ _____ |
| 2. AGD Constituent Dues: .....                            | \$ _____ |
| 3. AGD Component Dues: .....                              | \$ _____ |
| Total Amount Enclosed: .....                              | \$ _____ |

Individuals joining July 1 to Sept. 30, 2026, 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, 2025, enjoy membership through the end of 2026. Paid dues will be applied to the upcoming year.

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

† Please note that credit card payments are subject to an additional 3% processing fee not reflected in the dues total shown.

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, 2026. Contact the AGD or visit [agd.org](https://agd.org) for updated rates.

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,<sup>†</sup> please apply online at [agd.org/membership](https://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