



# APPLICATION FOR MEMBERSHIP

P O Box 19700, San Diego, CA 92159  
(Telephone) 800-836-2484 (FAX) 619-466-0999

Please provide the following information so that we may better serve your needs.

- Mr. ( )  M  
 1. Ms. ( )  F  
 Dr. ( ) (Last) (First) (Middle Initial) (Degree)  
 2. Nickname \_\_\_\_\_ Spouse's Name \_\_\_\_\_  
 3. CAD/CAM User?  Yes  No CEREC E4D User since \_\_\_\_\_  
 4. What percentage of your practice is devoted to CAD/CAM dental procedures? \_\_\_\_\_

The following will be used for the ACCD website Member's referral links:

5. Business / Practice Name: \_\_\_\_\_  
 Business Address: \_\_\_\_\_  
(Street)  
 \_\_\_\_\_  
(City) (State) (Zip) (Country)  
 Business Phone: (\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_  
(Area Code) (Area Code)  
 E-mail Address: \_\_\_\_\_  
 Website URL for Referral Listing: \_\_\_\_\_

### Personal Information

6. Home Address: \_\_\_\_\_  
(Street)  
 \_\_\_\_\_  
(City) (State) (Zip) (Country)  
 Home Phone: (\_\_\_\_) \_\_\_\_\_ Home Fax: (\_\_\_\_) \_\_\_\_\_  
 7. Date of Birth: \_\_\_\_\_ What year did you begin practicing dentistry? \_\_\_\_\_ Specialty: \_\_\_\_\_  
Month Day Year  
 8. Have you previously been a member of The ACCD (ACDNA)?  Yes When? \_\_\_\_\_  No  
 9. Dental/Medical Education: \_\_\_\_\_ Year: \_\_\_\_\_  
(Institution) (Degree)  
 10. Graduate Education: \_\_\_\_\_ Year: \_\_\_\_\_  
(Institution) (Degree)  
 11. Postgraduate Education: \_\_\_\_\_  
 12. University Affiliation: (Teaching or Research) \_\_\_\_\_  Full-time  Part-time

13. Are you a member of the ADA?  Yes  No  ADA No: \_\_\_\_\_  
AGD?  Yes  No  AGD No: \_\_\_\_\_

Other National Dental Associations?  Yes  No  Name: \_\_\_\_\_

14. Licensed in what States/Provinces/Countries? \_\_\_\_\_

15. Other Affiliations: (Hospitals, Government, Military, etc.) \_\_\_\_\_  
\_\_\_\_\_  Full-time  Part-time

16. Publications and Presentations: \_\_\_\_\_  
Attach if Necessary

17. Participation in Professional Organizations: (Include offices and committee chairmanships) \_\_\_\_\_  
Attach if Necessary

18. I am interested in the following  Conference Committees  Technology Committees  
 Board Positions  Local Chapters  
 Meeting Hospitality Host  New Members Committee  
 Industry Partners Committee,  Publications Committee

Signature of Applicant: \_\_\_\_\_ Date: \_\_\_\_\_

**MEMBERSHIP DUES MUST ACCOMPANY THIS APPLICATION**

Please check appropriate Membership category below:

- |  |   |                                   |   |       |
|--|---|-----------------------------------|---|-------|
| <input type="checkbox"/> Doctor                        | <input type="checkbox"/> Lab Technician/Owner | <input type="checkbox"/> Military | <input type="checkbox"/> Faculty/Research | \$365 |
| <input type="checkbox"/> Hygienist                     | <input type="checkbox"/> Dental Assistant     |                                   |   | \$300 |
| <input type="checkbox"/> Student                       |   |                                   |   | \$200 |
| <input type="checkbox"/> Corporate/Industry Membership |   |                                   |   | \$750 |

Total Annual Dues \$ \_\_\_\_\_

**Make checks payable to: Academy of CAD/CAM Dentistry**  
**Or we accept:**

American Express/ Master Card / Visa # \_\_\_\_\_ Exp Date: \_\_\_\_\_  
(Please Circle)

CVV Code \_\_\_\_\_

Name on Card \_\_\_\_\_

Signature \_\_\_\_\_

Return Application and payment to: Academy of CAD/CAM Dentistry  
P O Box 19700, San Diego, CA 92159  
Or Fax to: 619-466-0999  
Or online registration at <http://www.acadcamdent.com>