American Association of Women Dentists

Membership Application

Name: _____ Credentials: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Dental School (for student members): _____

Primary Office Address: _____

City: _____ State: _____ Zip: _____

Primary Phone Number: _____ Work Phone Number: _____

Email Address: _____

Membership Information

Please Select Membership Type:

Membership Category	**Dues**	**Amount Due**
Active	$219.00	
Federal Services	$101.00	
Faculty	$101.00	
Affiliate	$219.00	
Student: 1 Year	$55.00	
Student: 4 Years	$180.00	
1st Year Post Graduate	$55.00	
2nd Year Post Graduate	$110.00	
3rd Year Post Graduate	$165.00	
Sponsor a Student Membership*	$55.00	
** Please include Student Name and Application (Required).*	**Total:**	

Chapter Information

Please Select Chapter Type:

☐ Local

☐ Student

**(Required)* Name of Chapter:

_____

Please contact the AAWD National Office for more information on Chapters.

Payment Method:

☐ Check* ☐ American Ex. ☐ Visa ☐ Master Card

Name on Card: _____

Credit Card #_____

Expiration:_____ CVV Code:_____

Billing Address:_____

_____

*Please make checks payable to: **AAWD**

Mail to: AAWD National Office
7794 Grow Drive
Pensacola, FL 32514