



American Association of Women Dentists

Student Chapter Form

Name: _____ Credentials: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Dental School (for student members): _____

Primary Phone Number: _____ Cell Phone Number: _____

Email Address: _____

Student Dues Information

Please Select Membership Type:

<u>Membership Category</u>	<u>Dues</u>	<u>Amount Due</u>
Student: 1 Year	\$55.00	
Student: 4 Years*	\$180.00	
* Only applicable for first year students.	Total:	

Membership Status: New Renewal

Additional Information

Name of Chapter *(Required): _____

Will you be graduating this year? Yes No

Please provide alternate mailing address and Email in order to continue receiving AAWD membership information and updates post-Graduation.

Alternate Mailing Address: _____

Alternate Email Address: _____

Payment Method:

American Express Visa Master Card

Name on Card: _____

Credit Card #: _____

Expiration: _____ CVV Code: _____

Signature: _____

Billing Address: _____

Email Receipt to: _____

Check*

Check #: _____

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

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

Dues paid to AAWD Student Chapter

Amount: _____