American Association of Women Dentists
Student Chapter Form

Name: [Provide name]

Mailing Address: [Provide mailing address]

City: [Provide city]
State: [Provide state]
Zip: [Provide zip code]

Dental School (for student members): [Provide dental school name]

Primary Phone Number: [Provide primary phone number]
Cell Phone Number: [Provide cell phone number]

Email Address: [Provide email address]

Student Dues Information

Please Select Membership Type:

<table>
<thead>
<tr>
<th>Membership Category</th>
<th>Dues</th>
<th>Amount Due</th>
</tr>
</thead>
<tbody>
<tr>
<td>Student: 1 Year</td>
<td>$55.00</td>
<td></td>
</tr>
<tr>
<td>Student: 4 Years*</td>
<td>$180.00</td>
<td></td>
</tr>
</tbody>
</table>

*Only applicable for first year students.

Membership Status: [Select New or Renewal]

Additional Information

Name of Chapter*(Required):

_________________________  ______________________  ____________

Will you be graduating this year? [Select Yes or No]

Payment Method:

☐ American Express  ☐ Visa  ☐ Master Card

Name on Card: [Provide name on card]
Credit Card #: [Provide credit card number]
Expiration: [Provide expiration date]
CVV Code: [Provide CVV code]
Signature: [Provide signature]

Billing Address:

________________________________________
_____________________________________________________

Email Receipt to: [Provide email address]

☐ Check*
Check #: [Provide check number]

*Please make checks payable to: AAWD

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

☐ Dues paid to AAWD Student Chapter
Amount: [Provide amount]

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