American Association of Women Dentists

Membership Application

Name: Credentials:

Permanent 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 Dentist	$219	
Federal Services	$101	
Faculty	$101	
Retiree	$101	
Affiliate or International	$219	
Student: 1 Year Only	$55	
Student: 4 Years	$180	
Year 1 Postgraduate/Resident	$55	
Year 2 Postgraduate/Resident	$110	
Year 3 Postgraduate/Resident	$165	
Sponsor a Student Membership (*Student name and application required.)*	$55	
Smiles for Success Donation Other	$100 $_____	
	Total:	

Chapter Information

Please Select Chapter Type:

☐ Local

☐ Student

**(Required)* Name of Chapter:

_____

Please contact the AAWD National Office at 800-920-2293 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