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	$45	
Student: 4 Years	$149	
Year 1 Postgraduate/Resident	$55	
Year 2 Postgraduate/Resident	$110	
Year 3 Postgraduate/Resident	$165	
Sponsor a Student Membership (*Student name and application required.)*	$45	
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