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	With Auto Renew
Active Dentist	$280		$260
Federal Service/Faculty	$140		$130
Retiree	$140		$130
Affiliate or International	$280		$260
Student: 1 Year Only	$65		$65
Student: 4 Years	$130		$130
Year 1 Postgraduate/Resident	$65		$65
Year 2 Postgraduate/Resident	$130		$130
Year 3 Postgraduate/Resident	$165		
Sponsor a Student Membership *(Student name required.)*	$45		
Smiles for Success Donation	$100 **OR** $______		
	Total:		

Payment Method:

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

Name on Card: ______________________

Credit Card #______________________

Expiration:______________ CVV Code:______________

Billing Address:______________________

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Chapter Information

Please Select Chapter Type:

☐ Local

☐ Student

**(Required)* Name of Chapter:

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Please contact the AAWD National Office at 800-920-2293 for more information on chapters.

*Please make checks payable to: **AAWD**
Mail to: AAWD National Office
7794 Grow Drive,
Pensacola, FL 32514