



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:

<u>Membership Category</u>	<u>Dues</u>	<u>Amount Due</u>	<u>With Auto Renew</u>
Active Dentist	\$280		\$260
Federal Service/Faculty	\$140		\$130
Retiree	\$140		\$130
Affiliate or International	\$280		\$260
Student: 1 Year Only	\$45		\$45
Student: 4 Years	\$130		\$130
Year 1 Postgraduate/Resident	\$65		\$65
Year 2 Postgraduate/Resident	\$130		\$130
Sponsor a Student Membership (<i>Student name required.</i>)	\$45		
Smiles for Success Donation	\$100 OR \$_____		
	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.

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

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

Payment Method:

- Check* American Ex. Visa Master Card

Name on Card: _____

Credit Card #: _____

Expiration: _____ CVV Code: _____

Billing Address: _____