



American Association of Women Dentists

Membership Application

Name: _____ Credentials: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Permanent Email: _____

Primary Phone Number: _____ Work Phone Number: _____

Dental School (for student members): _____

Primary Office Address: _____

City: _____ State: _____ Zip: _____

Please Select Membership Type:

<u>Membership Category</u>	<u>Dues</u>	<u>Auto-Renew</u> <i>Credit or Debit Card Only</i>	<u>Amount Due</u>
Active Dentist	\$280	\$260	
Federal Service/Faculty	\$140	\$130	
Retiree	\$140	\$130	
Affiliate	\$280	\$260	
International * <i>(Any licensed dentist outside the US or Canada)</i>	\$20	\$20	
Student: 1 Year Only	\$45	\$45	
Student: 4 Years	\$130	\$130	
Postgraduate Year 1	\$65	\$65	
Postgraduate Year 2	\$130	\$130	
Sponsor a Student Membership <i>(Student name required.)</i>	\$45		
Smiles for Success Donation	\$100 OR \$_____		
Total:			

Please Select Chapter Type:

- Local Chapter
- Student Chapter

(Required) Name of Chapter: _____

***For international members**, please attach a scanned copy of your dental school diploma with this application. If you cannot attach a copy, fax a copy to the AAWD National Office at (850) 484-8762 or email it to membership@aawd.org.

Payment Method:

- Check** American Ex Visa Mastercard

Name on Card: _____

Credit Card #: _____

Expiration: _____ CVV Code: _____

Billing Address (if different): _____

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