

AAWD Membership Application

American Association of Women Dentists

Our mission: To become the recognized resource for connecting and enriching the lives of women dentists.

Please provide all of the information below and return it by mail to: AAWD, 216 West Jackson Blvd., Suite 625, Chicago, IL 60606; or fax to: (312) 750-1203; or download an application on-line at www.aawd.org.

Name: _____ Degree: _____

Company Name: _____

Street Address: _____

City/State/Zip: _____

Tel: _____ Fax: _____

E-Mail: _____ Web Site: _____

Home Address: _____

City/State/Zip: _____

Home Tel: _____

I prefer information be mailed to my home work address

Dental School Attended: _____ Year of Graduation: _____

Specialty: _____

Primary Practice Setting (Private or Group Practice, Health Service) : _____

Are you a member of: ADA AGD ASDA Other _____

Check here if you are interested in volunteering for AAWD Committees.

Are you a member of a local AAWD Chapter? (Chapter Name): _____

Dues Information for 2010 Membership Year

- \$215 Active (Woman Dentist) Member
- \$215 Affiliate Member
- \$99 Full-Time Faculty
- \$99 Federal Services
- \$95 New Dentist Member (1st year after graduation)
- \$45 Student Member
- \$95 Dental Office Team Member

Payment information: Visa MasterCard American Express Check/Money Order

Credit Card Number: _____ Sec. Code: _____

Billing Zip Code: _____ Exp. Date: _____

Amount Authorized: _____ Signature: _____

Questions? Call AAWD Headquarters at (800) 920-2293.

