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:

Membership Category	Dues	Auto-Renew *Card Only*	Amount Due
Active Dentist	$280	$260	
Full-time Faculty	$140	$130	
Federal Service	$140	$130	
Retiree	$140	$130	
Affiliate	$280	$260	
International * *(Any licensed dentist outside the US or Canada)*	$20	$20	
Student: 1 Year Only	$45	$45	
Student: 4 Years	$130		
Postgraduate Year 1	$65		
Postgraduate Year 2	$130		
Sponsor a Student Member (*Student name required.)*	$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