American Association of Women Dentists

Student Chapter Form

Name: ______________________ Credentials: ______________________

Mailing Address: ______________________

City: ______________ State: ________ Zip: ________

Dental School (for student members): ______________________

Primary Phone Number: ______________ Cell Phone Number: ______________

Email Address: ______________________

Student Dues Information

Please Select Membership Type:

Membership Category	**Dues**	**Amount Due**
Student: 1 Year	$65.00	
Student: 4 Years*	$180.00	
** Only applicable for first year students.*	**Total:**	

Membership Status: ☐ New

☐ Renewal

Additional Information

Name of Chapter *(Required)*:

____

Will you be graduating this year? ☐ Yes ☐ No

Please provide alternate mailing address and Email in order to continue receiving AAWD membership information and updates post-Graduation.

Alternate Mailing Address:

____

____

Alternate Email Address: ______________________

Payment Method:

☐ American Express ☐ Visa ☐ Master Card

Name on Card: ______________________

Credit Card #: ______________________

Expiration: ______________ CVV Code: ______________

Signature: ______________________

Billing Address: ______________________

____

Email Receipt to: ______________________

☐ Check*

Check #: ______________________

Please make checks payable to: **AAWD*

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

☐ Dues paid to AAWD Student Chapter

Amount: ______________________