FLORIDA ACADEMY OF PEDIATRIC DENTISTRY

Membership Application

Classification Requested: □Active □Associate □Affiliate
□Life □Retired □Faculty □Student □Honorary

Please Print

Personal Information

Name: ____________________

Office: ____________________

City: __________ State: ______ Zip: ______ Country: __________

Telephone: (_____) __________ Social Security No.: __________

Fax Number: (_____) __________ E-mail Address: __________

Mailing Address: ____________________

City: __________ State: ______ Zip: ______ Country: __________

Telephone: (_____) __________

□ Male □Female Birthdate: ______ Birthplace: __________

Professional Information

Member of: □American Dental Association # __________

□American Academy of Pediatric Dentistry # __________

Are you a Diplomate of the American Board of Pediatric Dentistry? ____ Certification Date ____

Are you formally trained in any other recognized dental specialty? __________

Are you Board certified or Board eligible in any other recognized dental specialty? ______

Are you a current or former member of this Academy? __________

Previous or current classification? __________

Date of discontinuation ______ Reason? __________

Professional awards of honors __________

____

Offices held in professional organizations and bibliography of publications: __________

____

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FLORIDA ACADEMY OF PEDIATRIC DENTISTRY

Professional Training **(Month/Year)**

	Institution	From	To	Degree/Certificate
Dental:				
Advanced Pediatric Dental Training:				
Other Advanced Training:				

Chronological List of Activity

From (Month/Year)	To	Place	% in Pediatric Dentistry: Practice	Teaching	Research	Areas other than Pediatric Dentistry

References
(see Procedures for Membership)

1. ____________________ 2. ____________________

Signature: ____________________ **Date:** ____________________

Have you enclosed a copy of your certificate in Pediatric Dentistry?

Application fee is $10.00. (non-refundable) (Make checks payable to F.A.P.D.)

Mail application to:

Dr. Robert Primosch, Executive Director
Florida Academy of Pediatric Dentistry
P.O. Box 100426 Health Science Center
University of Florida College of Dentistry
Gainesville, FL 32610-0426

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Headquarters Office use only:
Dates of Academy Membership: __________ Approved: ____ Denied: ____ Reason: __________

Signed: ____________________ Date: ____________________