AADGP Membership Application

We/I hereby apply for membership in the American Academy of Dental Group Practice and agree to abide by the Constitution and bylaws of the Academy.

Name of Organization _____
Address of Organization _____
City _____ State _____ Zip _____
Phone ( ) _____ Fax ( ) _____ Email _____
Primary Contact Person _____ Date: _____

Please indicate membership category you are applying for:

o **Dental Group Practice:** $150.00
(Initial year fee is $150 per group. Thereafter, annual dues are $150 per group, plus $75 for a primary administrator and $10 per each dentist and each additional member of the group.)
List dentists and/or practice administrators to be included in membership (Attach additional sheets if necessary):

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

o **Individual Practitioner / Practice Administrator:** $150.00
(Initial year fee is $150 per solo practitioner/individual. Thereafter, annual dues are $150 per solo practitioner/individual.) Individual's Name _____

o **Government or Educational Organization:** $100.00
(Initial year fee is $100 per group. Thereafter, annual dues are $75 per group.)
Primary Contact Person _____

o **Corporate Member:** Annual fee is $500.00 per organization.
(Any company that provides services to dental group practices, and whose concept of dental care delivery coincides with the philosophy and purpose statement of this Academy.)
President/CEO's Name _____

o **Associate Member:** Annual fee is $500.00 per organization.
(Practice management companies that own, develop and/or manage the business and/or marketing activities of dental group practices and facilities.)
President/CEO's Name _____

Payment can be made by check or credit card:

o Check Enclosed, Payable to **AADGP** Check Number: _____

Charge my:

o Visa o MasterCard o AmEx o Diner's Club

_____
CREDIT CARD NUMBER EXPIRATION DATE CSV/CID Code

_____
CARDHOLDER'S NAME(as it appears on the card) CARDHOLDER'S SIGNATURE

_____
CARDHOLDER'S ADDRESS (if same as company address please write same)

_____
CARDHOLDER'S CITY STATE ZIP/POSTAL CODE

Mail or Fax application and payment to:
American Academy of Dental Group Practice
2525 E. Arizona Biltmore Circle, Suite 127, Phoenix, AZ 85016 **FAX: 602.381.1093**