# 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 *(AADGP reserves the right to review & correct membership category & charge or bill the difference as necessary)*:

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. _____ 3. _____
2. _____ 4. _____

o **Individual Practitioner / Dental Office Administrator:** $150.00
(Initial year fee is $150 per solo practitioner/dental office administrator. Thereafter, annual dues are $150 per solo practitioner/dental office administrator.) Person'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 _____
(Choose one) Labels by Practice _____ Labels by Dentist _____

o **Associate Member:** Annual fee is $500.00 per organization.
(Practice management companies or individuals 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 DATE

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

_____
CARDHOLDER'S CITY STATE ZIP/POSTAL CODE

**Mail, Fax, or Email application and payment to:**

American Academy of Dental Group Practice
401 W. St. Charles Road, Lombard, IL 60148

**EMAIL:** aadgp@aadgp.org
**FAX: 630.510.4501**