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, $25 per additional location listing, 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 organization. Thereafter, annual dues are $100 per organization.)
Primary Contact Person _____

o **Corporate Member:** Annual fee is $500.00 per organization, plus $25 per additional location listing.
(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, plus $25 per additional location listing.
(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 or Email application and payment to:
American Academy of Dental Group Practice
2525 E. Arizona Biltmore Circle, Suite 127, Phoenix, AZ 85016

EMAIL: info@aadgp.org