



American Academy of Periodontology
 Membership Department
 737 N. Michigan Avenue, Suite 800
 Chicago, Illinois 60611-6660
Voice: 800-282-4867
Fax: 312-787-3670
Web site: www.perio.org

2008 STUDENT MEMBERSHIP APPLICATION

Student Membership Qualifications: Any person shall be eligible to be a Student Member who is continuously enrolled in a 3 year training program in periodontology accredited by the Commission on Dental Accreditation of the American Dental Association. Student members may remain such for up to two years after graduation, during which period their practice, if any, must be limited to periodontology. 2008 Membership Dues Fee: \$109 - Calendar year: January-December 2008. Membership includes issues of the *Journal of Periodontology*: January-December 2008. **Please allow 4-6 weeks for delivery of *Journal* back issues. If application is received after November 1, 2008, it will automatically be credited toward the 2009 calendar year and your *Journal* subscription will begin in January 2009.** Any questions regarding this application contact the Membership Department at 800-282-4867 or Email: member.services@perio.org Please type or print clearly and include an endorsement from your Periodontal Program Director.

1. **NAME** _____ **Check One:** ()DDS ()DMD
 (First, Middle Initial, Last)

2. **HOME ADDRESS:** _____
SCHOOL ADDRESS: _____

I wish to have my mail sent to (Check One): () Home Address () School Address

PRIMARY PHONE NUMBER () _____ **This is my (Check One):** () School #
 () Home #

CELL PHONE NUMBER (If not listed above): () _____
 Cell # _____

FAX NUMBER () _____ **EMAIL** _____

3. **DATE OF BIRTH** _____ **GENDER** ()M ()F

4. **PLACE of LICENSURE** _____ **DENTAL LICENSE NO.** _____

5. **DENTAL EDUCATION: Dental School** _____
 Degree _____ Date _____

6. **LIST YOUR AMERICAN DENTAL ASSOCIATION MEMBERSHIP NUMBER:** _____

PROGRAM DIRECTOR'S ENDORSEMENT

THIS APPLICATION FORM IS NOT COMPLETE UNLESS THE SIGNATURE OF THE PROGRAM DIRECTOR OF THE DEPARTMENT OF PERIODONTOLOGY APPEARS IN THE INDICATED SPACES.

7. I certify that _____ is enrolled in graduate training in periodontics.
 He/she began his/her training on _____ 20_____ and will complete his/her training
 on _____ 20____. I further certify that the Council on Dental Education of the ADA accredits the program in which he/she is enrolled. Upon successful completion of the program the applicant will have met the formal training requirements for examination by the American Board of Periodontology.

Name of School _____

Program Director's Signature _____

Date _____

