

NCAPD Active Membership Application

Personal Information

Name: _____
Office Address: _____
City: _____ State: _____ Zip: _____ Country: _____
Telephone: (____) _____ Fax Number: _____
E-mail Address: _____
Mailing Address: _____
City: _____ State: _____ Zip: _____ Country: _____
Telephone: (____) _____
Male Female Birthdate: _____ Birthplace: _____

Professional Information

Member of: American Dental Association # _____
National Dental Association # _____
Foreign Equivalent _____
Are you a Diplomat 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 member of the American Academy of Pediatric Dentistry? _____
Are you a current member of the Southeastern Society of Pediatric Dentistry? _____

Professional Training (Month/Year)

Institution From To Degree/Certificate

Dental: _____
Advanced Pediatric Dental Training: _____
Other Advanced Training: _____

References: Please list two NCAPD members who can provide references for you.

1. _____ 2. _____

Have you enclosed a copy of your certificate in Pediatric Dentistry and \$20 check for application fee?

Signature: _____ Date: _____

Mail Application with copy of certificate and check to:
NCAPD c/o Sarah Howard
Department of Pediatric Dentistry
CB# 7450, 228 Brauer Hall
Chapel Hill, NC 27599-7450
Phone: 919-966-2739 Fax: 919-966-7992 Web: www.ncapd.net

Headquarters Office use only: Approved: _____ Denied: _____ Reason: _____
Signed: _____ Date: _____ **Headquarters**

Office use only: Approved: _____ Denied: _____ Reason: _____
Signed: _____ Date: _____