



NCAPD Affiliate Membership Application

ELIGIBILITY: This category of membership is available, upon application, to a dentist or other person who does not meet the eligibility requirements for active membership but who has a demonstrable interest in pediatric dentistry by virtue of their activity in dental practice, dental education, dental research or dental program administration. Application for affiliate membership must be approved by the Board and receive the affirmative vote of a majority of the members present, entitled to vote and voting at a regularly called meeting of the NCAPD.

PRIVILEGES: Privileges of the Affiliate members shall be to:

1. Serve on committees; but not vote or hold office. Committee appointment is by nomination of the President and confirmed by majority vote of the Board.
2. Attend the annual meeting of the NCAPD.
3. Receive copies of all general membership communications and publications.
4. Affiliate members may not use the NCAPD name, membership status or logo, nor imply special expertise or training in pediatric dentistry.

FEES:

Application Fee to be returned with application: \$10 (nonrefundable)

Annual Dues* (calendar year: January 1 – December 30) \$25

**You will be invoiced for dues upon membership approval.*

All payments must be made in U.S. funds by check.

Please type or print legibly

PERSONAL INFORMATION

Name: _____
Last First Middle Initial

Gender: M F Birthdate: (M/D/Y) _____ Birthplace: _____

OFFICE ADDRESS

Street Address: _____

City: _____ State: ____ Zip: _____ Country: _____

Telephone: _____ Fax: _____

Email Address: _____

Website Address: _____

MAILING ADDRESS: home business

Street Address: _____

City: _____ State: ____ Zip: _____ Country: _____

Telephone: _____

PROFESSIONAL INFORMATION

FOR DENTISTS ONLY:

American Dental Association #: _____

National Dental Association #: _____

Foreign Equivalent: _____

Other: _____

PROFESSIONAL TRAINING

Dental (Predoctoral): Institution: _____
From/To (M/Y) _____ Degree/Certificate _____

What is your affiliation with pediatric dentistry? _____

Are you board certified or board eligible in any other recognized dental specialty? _____

Have you ever been a member of the NCAPD? _____

NON-DENTISTS, PLEASE ANSWER THE FOLLOWING QUESTIONS:

If you are not a dentist, please list your profession here: _____

Are you a member of any professional organizations? _____

PROFESSIONAL TRAINING

Undergrad: Institution: _____
From/To (M/Y) _____ Degree/Certificate _____

Graduate: Institution: _____
From/To (M/Y) _____ Degree/Certificate _____

Other: Institution: _____
From/To (M/Y) _____ Degree/Certificate _____

What is your affiliation with pediatric dentistry? _____

REFERENCES

If possible, please provide us with two NCAPD members who can provide references for you.

1. _____

2. _____

By signing and submitting this application, I acknowledge that I agree to abide by the constitution and bylaws and rules of this organization.

Signature _____ Date: _____

PAYMENT

My check is enclosed with payment of \$10 application fee.

Please mail payment to:

Sarah Howard, Dept. Pediatric Dentistry, UNC School of 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: _____