NCAPD Student Membership Application

Please print. No application fee required

Personal Information

Name: _____
Last First Initial

Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____ Fax: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____

☐ Male ☐Female Birthdate: _____ Birthplace: _____

Professional Information

Member of:
☐ American Dental Association # _____
☐ National Dental Association # _____
☐ Foreign Equivalent _____

Are you applying for:
☐ Student Membership ☐ Full-time ☐ Part-time
☐ Extension of Student Membership Reason: _____
Indicate additional postgraduate program under Professional Training below
☐ Transfer to Student Membership
Indicate accredited pediatric dental training program you are enrolling in: _____
(Also list under Professional Training below)

Professional Training

(Month and Year)

	Institution	Began Program Date	Graduation Date (or anticipated)	Degree/Certificate
Dental				
Accredited Pediatric Dental Training				
Other Degrees/ Advanced Training				
Postgraduate Program				

Signature: _____ Date: _____

If you are applying for an extension or transfer, your Program Director must send verification of your enrollment to the NCAPD Office.

Headquarters Office use only:

Previous NCAPD Membership: _____ Anticipated completion date: _____ Extended to: _____

Approved: _____ Denied: _____ Reason: _____

Signed: _____ Date: _____

NCAPD UNC School of Dentistry, CB#7450, 228 Brauer Hall, Chapel Hill, NC 27599-7450 Phone: 919-966-2739 Fax: 919-966-7992