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)	$75

**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:

NCAPD
Sarah Howard
P.O. Box 33
Bear Creek, NC 27207
Web: www.ncapd.net

Headquarters Office use only:

Approved: _____ Denied: _____ Reason: _____

Signed: _____ Date: _____