

# AADP MEMBERSHIP APPLICATION FORM

## INSTRUCTIONS FOR COMPLETION:

**This form is fillable and savable. Please download it to your computer and open it in Acrobat Reader BEFORE you begin filling in form.**



1. Complete the AADP membership application as thoroughly as possible. If you are interested in speaking, also complete the optional Speaker's Bureau information.
2. Furnish a current, color 5" x 7" photograph of yourself. An electronic version is acceptable; email with application form to Executive Director Kathy Uebel, [AADPA@aol.com](mailto:AADPA@aol.com) or [ExecutiveDirector@AADPA.org](mailto:ExecutiveDirector@AADPA.org).
3. **NO FEES ARE DUE AT THIS TIME.** Once you are approved as a member of AADP, an initiation fee of six-hundred, twenty-five dollars (US\$625) is due.
4. Member Annual Dues, billed each fall, are one thousand three hundred and ninety-five dollars (US\$1,395), which also covers your attendance at our annual meeting. Your first dues will be billed the September AFTER your selection.
5. We conduct personal interviews by phone prior to the Annual Meeting or face-to-face interviews at the Annual Meeting. The Membership Committee will contact you to set up your interview. Final decision on selection of new members is determined at the Annual Meeting, and installation as a New Member occurs the following year at the Annual Meeting.

## PLEASE COMPLETE IN DETAIL, USING ADDITIONAL SHEETS WHERE NEEDED

Name (Last, First, Middle) \_\_\_\_\_

Preferred name \_\_\_\_\_

Office address (Street, City, State, Zip) \_\_\_\_\_

Office telephone (\_\_\_\_\_) \_\_\_\_\_ Fax number (\_\_\_\_\_) \_\_\_\_\_

Home address (Street, City, State, Zip) \_\_\_\_\_

Home phone (\_\_\_\_\_) \_\_\_\_\_ Personal cell phone (\_\_\_\_\_) \_\_\_\_\_

Personal email address \_\_\_\_\_

Date of birth (Month/Day/Year) \_\_\_\_\_

Dental degree: School \_\_\_\_\_ Year \_\_\_\_\_

Degree designation: D.D.S. \_\_\_\_\_ D.M.D. \_\_\_\_\_

Specialty degree: School \_\_\_\_\_ Year \_\_\_\_\_

Degree designation \_\_\_\_\_ Other degrees \_\_\_\_\_

Professional organizations/affiliations \_\_\_\_\_

Type of practice (dentist) \_\_\_\_\_

*General or Specialty, Group, Solo, Etc.*

Type of business (non-dentist) \_\_\_\_\_

Business name \_\_\_\_\_ Years in business \_\_\_\_\_

Are you associated with a teaching institution?  Yes  No  Full time  Part time Dates \_\_\_\_\_

Please provide the name, phone number and email of the person who inspired you to join AADP:

Name \_\_\_\_\_

Phone (\_\_\_\_\_) \_\_\_\_\_ Email \_\_\_\_\_

## CANDIDATE BIOGRAPHICAL SKETCH FOR

Name \_\_\_\_\_ Date \_\_\_\_\_

*Please write a biographical and professional sketch that would allow the Academy members to get to know you better. Please include information about family, professional organizations and affiliations as well as other interests and hobbies. (Feel free to attach a separate page if necessary).*

The Academy would like to encourage those interested in presenting or speaking within and outside of AADP. If that is your desire as well, please fill out as completely as possible the optional information for our AADP Speaker's Bureau.

I authorize the Academy to make inquiry concerning my qualifications for membership from any source, waiving any legal right that I may have against the Academy and its officials or against the persons supplying such information. I will not hold either the sources or the Academy liable for information provided or its use in the Academy's decision concerning my qualifications for membership.

Having read the aims and objectives of the American Academy of Dental Practice and being in agreement with them, I hereby submit this membership application for consideration. If invited to join, I will participate in the activities of the Academy to the best of my ability, permit inclusion of my name in any membership list, roster or directory that the Academy may publish, and be guided and governed by the policies, Constitution and By Laws of the Academy.

Signature \_\_\_\_\_

Signature not required on electronically filled form

Date \_\_\_\_\_

# AMERICAN ACADEMY OF DENTAL PRACTICE SPEAKER'S BUREAU QUESTIONNAIRE (Optional)

*(Please type, providing detailed information)*

Name (Last, First, Middle) \_\_\_\_\_

Preferred name \_\_\_\_\_

Office address \_\_\_\_\_

*Street*

*City*

*State*

*Zip Code*

Office telephone (\_\_\_\_\_) \_\_\_\_\_ Fax # (\_\_\_\_\_) \_\_\_\_\_

Type of practice \_\_\_\_\_ General or specialty \_\_\_\_\_

\_\_\_\_\_  
*Date of Birth*

\_\_\_\_\_  
*Dental School*

\_\_\_\_\_  
*Graduation Date*

Will you present programs or write articles as a service to the Academy?  Yes  No

*If yes, please list the subjects and program or article title which you might present. Please list only those subjects in which you feel qualified to be a teacher.*

| <u>Subject</u> | <u>Title</u> | <u>Program or Article</u> | <u>If Program,<br/>Time Required</u> |
|----------------|--------------|---------------------------|--------------------------------------|
| 1. _____       | _____        | _____                     | _____                                |
| 2. _____       | _____        | _____                     | _____                                |
| 3. _____       | _____        | _____                     | _____                                |
| 4. _____       | _____        | _____                     | _____                                |

Comment on any programs or articles:

Would you like to participate in a group presentation?  Yes  No

*If yes, on what subject?*

Will you offer your services to component societies, state, national or civic organizations?  Yes  No

# MEMBER NOMINATION FORM AMERICAN ACADEMY OF DENTAL PRACTICE

Please send this nomination form to:

Ms. Kathy Uebel, Executive Director  
1063 Whippoorwill Lane  
Palatine, IL 60067-7064  
847-934-4404 • Fax 847-934-4410  
AADPA@aol.com or ExecutiveDirector@AADPA.org

I nominate \_\_\_\_\_ for membership in the AADP (American Academy of Dental Practice) on the basis of clear evidence of leadership and outstanding contributions in the area of dental practice administration. I believe the nominee will uphold the objectives of the Academy.

*Please complete the Nominator's Support Statement. Your statement is very important to the membership committee. Please present, in your own words, why you feel this nominee should be considered for membership. Emphasize his/her involvement in practice management activities. List any achievements deserving special recognition. If necessary, attach additional typed sheet.*

## NOMINATOR

Name \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone \_\_\_\_\_

Date \_\_\_\_\_ Signature \_\_\_\_\_

Signature not required on electronically filled form

Nominator's Support Statement (*Attach additional typed sheet if necessary*):