NCAPD Active Membership Application

Personal Information

Name:_____

Office Address: _____

City:_____State:_____Zip:_____Country: _____

Telephone: (____)_____Fax Number: _____

E-mail Address: _____

Website 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 Diplomate 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. _____

Signature:_____ Date: _____

Mail Application with copy of certificate and check to:

NCAPD
c/o Sarah Howard
P O Box 33
Bear Creek, NC 27207

Phone: 919-545-4195 Web: www.ncapd.net

Headquarters Office use only:

Approved:_____Denied:_____Reason:_____

Signed:_____Date: _____