

# ACADEMY OF OPERATIVE DENTISTRY

## MEMBERSHIP APPLICATION

PLEASE CIRCLE: DR. MR. MRS. Ms.

FIRST NAME: \_\_\_\_\_ M.I: \_\_\_\_\_

LAST NAME: \_\_\_\_\_

STREET ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_

COUNTRY: \_\_\_\_\_

TELEPHONE: HOME: \_\_\_\_\_

OFFICE: \_\_\_\_\_

CELL: \_\_\_\_\_

FAX: \_\_\_\_\_

E-MAIL: \_\_\_\_\_

### THIS APPLICATION IS FOR THE FOLLOWING MEMBERSHIP CATEGORY:

\_\_\_\_\_ ACTIVE MEMBERSHIP

\_\_\_\_\_ AFFILIATE MEMBERSHIP

\_\_\_\_\_ STUDENT MEMBERSHIP  PRE-DOCTORATE  POST-GRADUATE

PRESENTLY ATTENDING THE FOLLOWING DENTAL SCHOOL:

\_\_\_\_\_  
**PROJECTED GRADUATION DATE:** \_\_\_\_\_

### DESCRIBE YOUR PRACTICE OF DENTISTRY:

\_\_\_\_\_ PRIVATE PRACTICE

\_\_\_\_\_ MILITARY: \_\_\_\_\_ ARMY \_\_\_\_\_ NAVY \_\_\_\_\_ AIR FORCE \_\_\_\_\_ PHS

\_\_\_\_\_ ACADEMIC: \_\_\_\_\_ FULL-TIME \_\_\_\_\_ PART-TIME

UNIVERSITY: \_\_\_\_\_

DEPARTMENT: \_\_\_\_\_

\_\_\_\_\_ OTHER: \_\_\_\_\_

**STUDY CLUB AFFILIATION:** \_\_\_\_\_

### PLEASE TELL US HOW YOU LEARNED ABOUT THE ACADEMY:

\_\_\_\_\_ PROFESSIONAL COLLEAGUE \_\_\_\_\_ DENTAL SCHOOL

\_\_\_\_\_ WEBSITE \_\_\_\_\_ OPERATIVE DENTISTRY JOURNAL

OTHER: \_\_\_\_\_

**SIGNATURE:** \_\_\_\_\_

**SPONSOR:** \_\_\_\_\_

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LOS ANGELES, CA 90034

OR FAX TO: 310. 825.2536