

**WASHINGTON STATE ACADEMY OF PEDIATRIC DENTISTRY
APPLICATION FOR MEMBERSHIP/ INFORMATION UPDATE**

Existing WSAPD Member

New Member Application

Name: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Telephone Numbers:

Office: _____ Home: _____

Fax telephone: _____

Email: _____

Member Category:

Fellow

Active

Life

Student

Associate

Honorary

Pediatric Dentistry Program Institution: _____

Degree/ Certificate: _____

Year: _____

Dental Organization Membership:

American Dental Association

National Dental Association

American Academy of Pediatric Dentistry

Other Dental Association:

Please List: _____

Practice Limited to Pediatric Dentistry: Yes

No

Primary Practice Setting: Clinical Academic

Research

Other

OFFICE USE ONLY _____

APPROVAL: COMMITTEE ON CREDENTIALS Yes

No

AFFIRMATIVE VOTE: _____ date Yes

No