

WSAPD Washington State Academy of Pediatric Dentists

**WASHINGTON STATE ACADEMY OF PEDIATRIC DENTISTS
APPLICATION FOR MEMBERSHIP 2010
ANNUAL MEMBERSHIP FEE: \$125**

PLEASE MAKE CHECK PAYABLE TO: WSAPD

AND MAIL TO:

**WSAPD - STEPHANIE COOK
P.O. BOX 99430
LAKEWOOD, WA 98496**

Name: _____ **Date:** _____

Mailing _____
Address: _____

Telephone Numbers: Fax Numbers:

Home: (____) _____ (____) _____
Office: (____) _____ (____) _____
e-mail _____

Membership Category:

Fellow _____ **Student** _____
Active _____ **Associate** _____
Life _____ **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** _____

ARRIRMATIVE VOTE: _____ **(DATE) YES** _____

NO _____