MEMBERSHIP APPLICATION

Select Membership Category: ☐Active ☐Associate ☐Affiliate ☐Life

Full Name:_____

Dental Degree:_____

Office Address:_____ZIP_____Office Phone:_____

Employer Name:_____Office Fax:_____

Cell Phone:_____ Email:_____**

**____Yes, please include my email in the membership directory.

**____Yes, you have my permission to release my email to annual meeting exhibitors.

Home Address:_____ZIP_____Home Phone:_____

For mailings, do you prefer we use: ☐home address ☐office address

If applicable, Spouse's Name:_____

Dental Degree:_____Year:_____

Other Degrees:_____Year(s)_____

Advanced Formal Training & Year(s):_____

_____

Are you Board Certified? ☐Yes ☐No Year:_____

Are you licensed to practice in Florida? ☐Yes ☐No Other States:_____

What year did you become a member of the American Board of Prosthodontics:_____

Presently, if you are part of a dental department in the Army, Navy, Air Force or Veterans Administration, give rank and date of beginning service:_____

*Are you a member of the ADA? ☐Yes ☐No List other dental organizations you belong to:

_____

*ADA membership is not a requirement for FPA Membership. However, all members are encouraged to become members of the American Dental Association.

Applicant's Signature:_____Date:_____

FPA Secretary:_____Date:_____

PLEASE ATTACH COPIES OF SUPPORTING DOCUMENTATION: Specialty Training Board Certification

Return this application to:
FPA, 1500 Gay Rd #3B Winter Park, FL 32789
Questions/Concerns: (770) 329-8026 or email: Floridafpa@gmail.com Fax: 407-895-9712

Do not fill out information below.

07/2016

Date application received_____ Amount received with application $_____Check #_____

Visit the FPA website at: www.thefpa.org