

**American Academy of Cosmetic Dentistry
Los Angeles Chapter**

APPLICATION FOR MEMBERSHIP

- Name_____
- Date of Birth_____ Degree_____ Specialty_____ License_____
- Business Address_____

- Business Phone_____ FAX_____ E-Mail_____
- Home Address_____

- Home Phone_____ FAX_____ E-Mail_____
- Dental/Medical Education_____ Year_____
- Graduate Education_____ Year_____
- How did you hear about AACD?_____
- Are you a member of National AACD? ___NO ___YES When_____
- Other Affiliations _____

- What types of Cosmetic Dentistry do you practice?_____

Annual Membership Dues: \$35.00

Signature_____ Date_____