International Resident Member Application

Eligibility

A dentist enrolled full-time in an advanced specialty education program in endodontics as defined by their country of residence.

Personal ID #

_____

(For AAE Office Use Only)

Personal Information

First Name | Middle Initial | Last Name

Nickname (if preferred) | Date of Birth (month/day/year)

Degrees/Designations

Email

Phone | Cell Phone

Fax | Website

Address 1

Select Status: ○ Home ○ Office ○ University ○ Other

Use this information for: ○ Shipping ○ Billing ○ Directory

Street Address | Suite/Apt.

City | State/Country | Zip/Postal Code

Address 2

Select Status: ○ Home ○ Office ○ University ○ Other

Use this information for: ○ Shipping ○ Billing ○ Directory

Street Address | Suite/Apt.

City | State/Country | Zip/Postal Code

Select: ○ Male ○ Female

Select Ethnicity (optional):

○ White/Caucasian ○ Asian/Pacific Islander ○ Black/African American

○ Hispanic/Latino ○ Middle Eastern ○ Other _____

Application Processing Instructions

Each application must contain the following:

1. Verification of enrollment in an advanced specialty education program in endodontics, an advanced placement program or a health-related program by the appropriate department head.
2. Submission of a signed letter from the university admissions representative or director of the advanced specialty education program in endodontics on official university letterhead confirming student status, written in English.
3. Payment of dues in U.S. currency.
4. Your signature and date.

Membership Dues Schedule

The membership dues cycle is based on the AAE fiscal year (July 1– June 30). Individuals submitting applications for International Resident membership through April will receive membership benefits for the current fiscal year. Applications received **May 1 through June 30** will be valid for the next membership fiscal year beginning July 1. Delivery of the *Journal of Endodontics* also begins in July.

International Resident Dues: $80 U.S.D.

Verification of Enrollment

"I herby verify that Dr. _____
is a dentist enrolled full-time in an advanced specialty program in endodontics as defined by their country of residence.

Signature

Print Name | Date

Title (Endodontic Program Director, Department Chair, Dean)

Education

Dental School | Country

Date Started | Graduation Date | Degree(s)

Advanced Specialty Education Program in Endodontics

Date Started | Graduation Date | Degree(s)

Other Graduate Schools/Programs

Date Started | Graduation Date | Degree(s)

Payment

○ Check in U.S. funds

Check Number | Amount

Check must be clearly printed in U.S. dollars.

Credit Card: ○ Visa ○ MasterCard ○ American Express ○ Discover

Card Holder's Name (print) | Amount

Card Number | Security Code | Expiration Date

I hereby apply for membership in the American Association of Endodontists and resolve to abide by the Association's Bylaws as well as the *Principles of Ethics and Code of Professional Conduct of the American Dental Association* if accepted into membership. If I have paid by credit card, my signature authorizes payment.

Signature | Date