

MoAPD Application

Name _____

Office Address _____

City _____ State _____ Zip _____

Office Phone () _____ Fax () _____

E-Mail _____ Office Website _____

Occupation: Pediatric Dentist Year Graduated _____

Orthodontist Year Graduated _____

General Dentist Year Graduated _____

Pediatric Dental Resident _____

Program and year you will finish training

Dental Student _____

Program and year you will finish training

Other _____

Signature _____

Today's Date _____

Please mail this application and \$50.00 annual dues
(Dues are \$25.00 if you are in your first year out of school or an AAPD Life Member)
(Dues are waived if you are a student or an AAPD Retired Member)

To: Dr. Craig S. Hollander
3555 Sunset Office Drive #210
Saint Louis, MO 63127