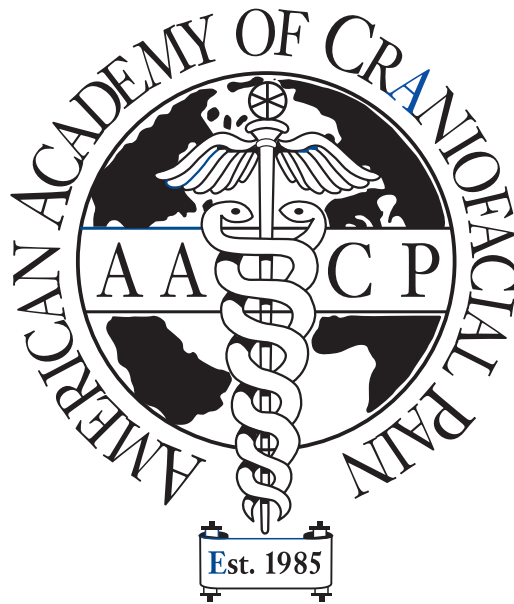


AMERICAN ACADEMY OF CRANIOFACIAL PAIN



*Leading the TMD
Community*

WELCOME TO THE AACFP

VISION: *The American Academy of Craniofacial Pain will continue to be the Craniofacial Pain/TMD organization representing all practitioners in this discipline by providing a common ground for advancement of knowledge, clinical practice and research.*

MISSION: *The American Academy of Craniofacial Pain is committed to the relief of Craniofacial Pain and dysfunction, and the advance of education and research in this field.*

“Leading the TMD Community” is more than a slogan. It is our guiding rule! To ensure that our members are heard, since 1985 the AACFP has been actively involved with:

- **Research organizations**, such as the National Institutes of Health (NIH) and the National Institute of Dental & Craniofacial Research (NIDCR).
- **Professional and political organizations**, including the American Dental Association (ADA), state and local dental associations, licensing boards and the Food & Drug Administration (FDA).
- **Ongoing clinical research** that elevates professional standards of diagnostic testing, treatment protocols and outcome effectiveness.
- **Student outreach** aimed at recognizing and supporting qualified senior dental students interested in the practice of Craniofacial Pain.

MEMBER BENEFITS

When you join AACP, you become a member of a committed community of health professionals. Each member receives:

- *A referral service listing on the AACP website to help prospective patients find a member in their area*
- *A subscription to CRANIO: The Journal of Craniomandibular Practice®, the official scientific journal of the AACP*
- *A subscription to TMDiary, the official news journal of the Academy, and the FMO newsletter*
- *Reduced fees at AACP symposiums and mid-winter meetings*
- *Reduced fees for AACP education programs*
- *Access to AACP monthly webinars*
- *Your own page with your photograph on the AACP website, giving your practice exposure on the Internet*
- *AACP lapel pin and membership certificate suitable for framing*
- *A listing in and access to the Membership Directory to facilitate professional networking*
- *Exclusive access to the "Members Only" section of the AACP Website where you'll find a members-only forum for posting questions and receiving advice, a Current Case Study and Current Clinical Tip, a bibliography of pertinent literature and more*
- *Preferred customer status with select AACP vendors serving the TMD community*

REQUIREMENTS FOR MEMBERSHIP

Dentists may enter the Academy at the Member level. In order to become a Member, one must possess a dental degree from an accredited university or college and must be licensed by the state in which he/she practices. Advancement to higher levels begins at the Member level. Additionally, one must possess a valid license to practice dentistry that is not revoked or suspended unless retired from dentistry or practicing where a license is not required, (e.g., military, full time teaching, etc.) and must possess satisfactory moral and ethical standards and abide by the Academy's Code of Ethics.

INTERESTED IN MEMBERSHIP?

Please fill out the information on the next page. Print legibly and fill in all applicable blanks. Return the completed form with the \$150 application fee to the AACP either in person to the representative or by mail (address listed below). Upon receipt of this form, the Executive Office will add your name to the Academy's permanent mailing list and deliver your information to our Membership Chairman and Committee. If accepted, you will be recommended for membership and your application will be voted on by the entire Board of Directors. This process usually takes 6 to 10 weeks. You will be notified of the result of the vote as soon as possible. At that time, you will be asked to submit additional data, which may include a photograph, membership directory information and other credentials. You will be billed for annual membership dues in the fall of the year. Membership dues are currently \$395/USA, \$420/Canada and \$440/all other countries.

Member levels include: *Member, Fellow-Eligible, and Fellow. Diplomate status is granted by ABCP.*

For more information about AACP, visit our website at www.aacfp.org.

AACP EXECUTIVE OFFICE
1901 N. ROSELLE ROAD, SUITE 920
SCHAUMBURG, IL 60195-3187
PHONE: 800-322-8651 • 847-885-1272
FAX: 847-885-8393
EMAIL: CENTRAL@AACFP.ORG
WEBSITE: WWW.AACFP.ORG

MEMBERSHIP APPLICATION

Instructions: Please print legibly. Provide all applicable information requested below and attach the \$150 application fee. Make check payable to AACP in U.S. dollars drawn on a U.S. bank **OR** submit VISA-MasterCard information on back page. Return to AACP representative or mail to the AACP address on the back of this form.

1. Full Name (including credentials, exactly as it should appear on official correspondence, certificates, etc.): _____

2. Mailing Address and Contact Information:

	OFFICE	HOME
STREET ADDRESS		
CITY/STATE/ZIP CODE		
PHONE/FAX		
EMAIL ADDRESS		
WEBSITE ADDRESS		

3. Education:

	INSTITUTION	LOCATION	DEGREE	DATE RECEIVED
UNDERGRADUATE				
GRADUATE				
INTERNSHIP				
RESIDENCY				
POST-DOCTORAL				

- 4. Have you ever been convicted of a felony (or comparable serious crime if referred to by some other name outside of the US)?** No Yes (If Yes, attach a statement of explanation.)
- 5. Healthcare profession in which you are licensed to practice:** _____
- 6. State/province/country in which you are licensed to practice:** _____
- 7. Has your license to practice ever been suspended or revoked or have you been notified of any currently pending investigation or review related to your license to practice?** (check one please) No Yes (If Yes, attach a statement of explanation.)
- 8. In light of AACP's membership requirements, please provide any other information not covered in response to the questions above that you believe is relevant to AACP's assessment of your application for membership.** (Attach a statement of explanation.)
- 9. Is your practice a specialty or limited practice?** (check one please) No Yes
If Yes, please list your specialty or limitation: _____
- 10. What percentage of your current practice involves Craniofacial Pain/TMD:** _____ %
- 11. How did you hear about AACP or who recommended that you apply for membership?**

In making this application to the American Academy of Craniofacial Pain, in accordance with and subject to its Articles of Incorporation, Bylaws and such other governing provisions as, from time to time, are in force, (hereinafter collectively referred to as its regulations), I agree to disqualification, suspension or revocation of membership and to surrender any Certificate of membership or competency of Fellowship in the event of any misstatement or misrepresentation of a material fact, any material submitted or in the event that any of the aforementioned regulations applicable to said membership or Fellowship Status are violated by me, as determined by the American Academy of Craniofacial Pain. I further agree to hold the American Academy of Craniofacial Pain, its officers, examiners, employees and agents, free from any claim, damage or liability by reason of action they or any of them may take in respect of this application, including, but not limited to, the failure of the American Academy of Craniofacial Pain to issue me membership, or the suspension, revocation or making of any demand for the surrender of an issued Certificate of membership or Fellowship Status or the removal of my name from any list of holders of such certificates.

In support of this application, I certify that all of the statements and/or affirmations made herein, including any statements of explanation, are true, complete and correct to the best of my knowledge and belief and are made in good faith and without mental reservations, and I agree that any false, incomplete or incorrect statements may serve as a basis for denial of my membership application, as well as disqualification, suspension or revocation of membership if already accepted.

Applicant's Signature: _____ **Date:** _____

I do not give permission (circle one) to AACP to contact me via fax, phone, email and/or postal mail. _____ initial here to give permission.



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800-322-8651 • 847-885-1272 • FAX: 847-885-8393

EMAIL: CENTRAL@AACFP.ORG • WWW.AACFP.ORG

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After completing your application form, please attach the \$150 application fee and return to the AACFP representative or mail to the address above. Checks may be made payable to the AACFP and must be in U.S. dollars drawn on a U.S. bank. If using VISA or MasterCard, please supply information below.

Method of Payment: Check Visa MasterCard

Card Number: _____

Expiration Date: _____ **Security Code:** _____ **Today's Date:** _____

Cardholder (*name as it appears on card*): _____

Billing Address for this credit card: _____

Cardholder's signature: _____

Office Use Only: Distributed: _____ **Received:** _____

Fee: _____ **Review Date:** _____ **By:** _____ **Accept: Y N**