



Application for The Accreditation Written Examination

Name: _____

Member ID: _____

Address: _____

Telephone: Work: (_____) _____

Home: (_____) _____

Fax: (_____) _____

E-mail: _____

Membership Type: Doctor Lab Technician

Requested written exam location and date: _____
(Must be filled in to be processed)

Application Requirements

1. Active member since: _____ (month/year)

2. Membership dues paid for the current year: (yes / no)

3. Application fee: \$400.00 non-refundable

Type of card: Visa MasterCard American Express

Card # _____ Expiration Date: _____

Card Security Code # _____

4. Have you applied for the written exam process at any previous time? yes no

If yes, when: _____ (year)

5. Request for postponement must be made in writing at least two months in advance; an administrative fee of US \$75.00 must be paid to reschedule. With less than two month's written notice, an administrative fee of US \$125.00 will be required to reschedule. Failure to appear for a scheduled written examination will result in forfeiture of the entire fee.

***It is agreed that, in the event of failure on the American Academy of Cosmetic Dentistry ("Academy") Accreditation Written Examination, the undersigned will not institute, nor aid in the institution or prosecution of, any action, suit or other claim against the Academy or any of its agents or employees for any damages, injury, loss or harm, of whatever nature or type, resulting or anticipated to result from such failure on the Accreditation Written Examination or related matters.

Signature

Date

Print Name