



APPLICATION FOR THE ACCREDITATION WRITTEN EXAMINATION

Name: _____

Member ID: _____

Address: _____

Telephone: Work: (_____) _____

Home: (_____) _____

Fax: (_____) _____

E-mail: _____

Membership Type: Dentist Laboratory Technician

Requested written examination location and date: _____
(Required for processing)

Application Requirements

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

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

3. Application fee: \$400 (USD) non-refundable

Type of card: Visa MasterCard American Express

Card # _____ Expiration Date: _____

Card Security Code # _____

4. Have you previously applied for the written examination process? yes no

If yes, when: _____ (year)

5. Request for postponement must be submitted in writing at least two months in advance; an administrative fee of \$75 (USD) must be paid if rescheduling. With less than two months written notice, an administrative fee of \$125 (USD) is 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