



APPLICATION FOR FELLOW MEMBERSHIP

Submit the application and attachments to the Headquarters Office. Retain one additional copy for your files. All requested information must be provided in detail and in such form that the date can be verified. Applications must be received in the Headquarters Office by the date specified on page 10. Type or print all information in English.

Do you require an interpreter? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, for which language? \_\_\_\_\_

Have you taken the Fellowship Examination before? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, when did you take the exam? \_\_\_\_\_
Month Year

1. Name \_\_\_\_\_
First Middle Last Degree

2. Office Address \_\_\_\_\_
No. Street Suite

City State Zip Country

Telephone Fax E-Mail Address

3. Home Address \_\_\_\_\_
No. Street Suite

City State Zip Country

Telephone

4. Date of Birth \_\_\_\_\_ Place of Birth \_\_\_\_\_

5. Dental Education

Name of institution Location Date Degree

6. Postdoctoral Education in Dentistry

Name of institution Location Type of Program Date Degree

Name of institution Location Type of Program Date Degree

7. Specialty Board Certification

Board	Year
Board	Year

8. Document at least 100 hours of continuing education in oral implantology and related subjects beyond that required for Associate Fellow membership. (Use additional sheet if necessary.) **Proof of attendance must be submitted.**

Date(s)	Title of Course	Sponsoring Institution	Subject Matter Code*	Total Hrs./ Participation Hrs.	Instructor

\*BS – Basic Science      E - Endodontics      ML - Medical/Legal      O - Occlusion  
 Per – Periodontics      P - Prosthetics      S - Surgery

9. Document attendance at an educational session or basic educational course offered by the American Academy of Implant Dentistry at either the national or district level, no more than two (2) years prior to taking the examination. **Proof of attendance must be submitted.**

10. Year inducted as Associate Fellow of the American Academy of Implant Dentistry \_\_\_\_\_

11. a. List countries, states or territories in which you are licensed to practice dentistry. Give acquisition dates and license numbers.

Country, State or Territory	Date	License Number

b. Have you ever had a license to practice dentistry revoked or suspended? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, attach a detailed explanation.

c. Is any disciplinary action pending with respect to your license to practice dentistry? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, attach a detailed explanation.

12. List all locations where you have practiced dentistry during the past ten years. If you did not maintain your own office, list the institutions or dentists by whom you were employed. Indicate the length of time spent at each location.

Institution or Dentist	Address	From	To

13. Which phase(s) of implant dentistry do you perform? Surgical \_\_\_\_\_ Restorative \_\_\_\_\_

14. Presentations

a. Original table clinics presented

Title	Name of Meeting	Date of Presentation

b. Original posters presented.

Title	Name of Meeting	Date(s) of Presentation

c. Original lectures presented to dental professionals.

Title	Name of Sponsoring Organization/Institution	Date of Presentation	# of CE hours

## 15. Publications

- a. Original professional articles published or accepted for publication in refereed dental journals.

Title of Article	Name of Publication	Issue, Year Published

- b. Original professional article published or accepted for publication in non-refereed dental publication

Title of Article	Name of Publication	Issue, Year Published

- c. Original articles published in public press

Title of Article	Name of Publication	Issue, Year Published

- d. Peer-reviewed electronic course related to implant dentistry

Title of Article	Internet Posting Address	Issue, Year Published

## 16. Professional Organization Activities

- a. Offices held in implant organizations or local/state dental societies

Office	Name of Organization	Year

b. Committees chaired in implant organizations or local/state dental societies

Office	Name of Organization	Year

c. Do you hold Fellowship in the Academy of General Dentistry? Yes \_\_\_\_\_ No \_\_\_\_\_  
 If yes, when was your Fellowship conferred? \_\_\_\_\_

d. Do you hold Mastership in the Academy of General Dentistry? Yes \_\_\_\_\_ No \_\_\_\_\_  
 If yes, when was your Mastership conferred? \_\_\_\_\_

17. Other

a. Implant Study Group Membership

Name of Study Group	Location	Meeting Schedule

b. Dental or Medical School Faculty Appointment

Institution	Title	Date From/To

c. Hospital Staff Privileges

Name of Hospital	Location	Type of Privileges

18. In the following table, provide information about the ten (10) cases that you will present for examination. For each case, place an "x" in each column that applies. Note: These cases must meet the requirements described in the Requirements for the Fellow Membership Examination and be ones for which you provided both the surgical and prosthetic phases of treatment.

Name of Patient	Complete Arch Case	Posterior Maxilla	Bone Deficiency	Completed Within 18 Months	In Function 5 years or More	Written Report
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						

19. List 40 additional implant cases that you have completed. Include each patient's current address and telephone number. Obtain permission from each patient for the Admissions and Credentials Board to contact them about their cases. Documentation of their permission is not required.

Patient Name	Address	Telephone Number
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		
16.		
17.		
18.		
19.		
20.		

Patient Name	Address	Telephone Number
21.		
22.		
23.		
24.		
25.		
26.		
27.		
28.		
29.		
30.		
31.		
32.		
33.		
34.		
35.		
36.		
37.		
38.		
39.		
40.		

**ACCEPTANCE OF CONDITIONS FOR APPLICATION**

**Knowledge of Requirements and Accuracy of Information**

I certify that I have read the *Requirements for the Fellow Membership Examination* and that the information in this application is true and correct in all material respects.

I acknowledge and understand that if any of the foregoing information is found to be false or misleading in any respect, the AAID in its sole discretion may terminate my membership.

I also understand that my case reports will become the property of the American Academy of Implant Dentistry.

**Authorization and Release**

I hereby grant the Admissions and Credentials (A & C) Board of the American Academy of Implant Dentistry and/or its authorized representatives permission to make general inquiries and to obtain information from any source, including my patients whose cases are used in the examination process, concerning my professional standing, reputation, skill, character and fitness as it deems appropriate.

I release and hold harmless the AAID and its authorized representatives from any and all liability relating to any such good faith inquiry made pursuant to my application for Fellow membership in the American Academy of Implant Dentistry.

I further release and hold harmless anyone responding, in good faith, to any such inquiry made by the A & C Board or its authorized representatives.

\_\_\_\_\_ Date

\_\_\_\_\_ Signature of Applicant

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**APPLICATION DEADLINES, FEES, and POLICIES**

Applications and fees for the Fellow examination must be submitted to the AAID Headquarters Office, Suite 750, 211 East Chicago Ave., Chicago, IL 60611-2616, by February 1. The application fee of \$950 is nonrefundable.

***Translation services for the oral/case examination are available upon request. The candidate will be responsible for all related fees. The fees will be based on the prevailing rates. Requests for translation services must be made at the time of application. Candidates will be notified of the fee and payment for the services must be received in the Headquarters Office at least 30 days prior to the examination date.***

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**PAYMENT**

Include payment of \$950. If you pay by check, the payment must be in United States dollars and must be drawn on a United States bank. Make checks payable to the American Academy of Implant Dentistry.

Check enclosed

Charge my:  Visa  MasterCard  Discover  American Express

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Account #

Exp. Date

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Signature

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Name on Credit Card (Please Print)