



a. Sciences Related to Implant Dentistry

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

b. Clinical Implantology and Related Course

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

Subject Matter Codes:

\*BS - Basic Science IM - Implant Modalities P - Prosthetics PM - Practice Management CME - Clinical/Medical Exams O - Occlusion Per - Periodontics S - Surgery G - Grafting

**APPLICATION DEADLINES, FEES AND POLICIES**

The Associate Fellow Examination has two parts: written and oral/case. The \$1,050 application fee, which is nonrefundable, covers both parts of the examination. **A \$250 fee will be charged to process the application for the Part 2 (oral/case) examination.**

Submit the completed Part 1 (written) application for receipt in the AAID Headquarters Office, Suite 750, 211 East Chicago Avenue, Chicago, IL 60611 by the deadlines announced for the examination format that you have chosen:

- Print examinations: thirty (30) days before the examination date
- Computer-based examinations: four (4) months before the first day of the examination period

Candidates must pass the written examination before applying for the oral/case part. The oral/case examination is given in Chicago once each year, typically in early May; that application deadline is February 1.

Those who pass Part 1 of the Associate Fellow examination have the option of challenging either Associate Fellow or Fellow membership examination (see Fellow Requirements for details). In either case, the oral/case examination must be completed successfully within four years after passing the Part 1 (written) examination; and candidates for the oral/case examination must be general members of the Academy in good standing.

**ACCEPTANCE OF CONDITIONS FOR APPLICATION**

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

\_\_\_\_\_ Date

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

**PAYMENT**

Include payment of \$1,050. 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 American Academy of Implant Dentistry. If you pay by wire transfer, attach a copy of the receipt from the bank; and your name **MUST** appear on the receipt.

Check enclosed

Receipt is attached for Wire Transfer from

\_\_\_\_\_ Name of Bank

Charge my:  Visa  MasterCard  Discover  American Express

\_\_\_\_\_ Account #

\_\_\_\_\_ Exp. Date Security Code

\_\_\_\_\_ Signature

\_\_\_\_\_ Name on Credit Card (Please Print)