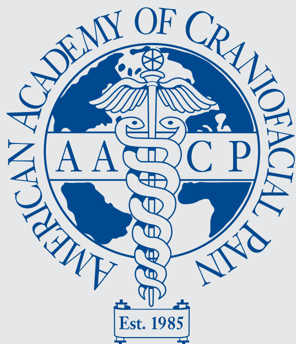
JOIN US

leading the
TMD and Dental Sleep Community



The American Academy of Craniofacial Pain is setting the standards in education and research while providing cutting edge training across the country and around the world.

Do you have an interest in craniofacial pain/TMD and dental sleep medicine?

AMERICAN ACADEMY OF CRANIOFACIAL PAIN

Associate Membership Application

Welcome to the AACP

VISION:

The American Academy of Craniofacial Pain will continue to be the organization promoting advancement of knowledge in Craniofacial Pain, Temporomandibular Disorders, and Dental Sleep Medicine by providing a common ground for clinical practice and research to professionals for the benefit of the public.

MISSION:

The American Academy of Craniofacial Pain is committed to the relief of craniofacial pain, temporomandibular disorders and dental sleep related disorders and supporting the advancement of education, research and dissemination of knowledge and skills in these areas.

"Leading the TMD and Dental Sleep Community" is more than a slogan. It is our guiding rule! To ensure that our members are heard, since 1985 the AACP 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.

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 *TMDiary*, the official news journal of the Academy, and the *FMO* newsletter,
- A subscription to the *AACP Examiner*, a bi-weekly email newsletter focused on hot topics in the world of craniofacial pain and dental sleep medicine,
- Reduced fees at AACP symposiums,
- Reduced fees for AACP education programs,
- Access to AACP 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, and
- EBSCO Publishing package subscription with access to hundreds of free full text medical journals.

Requirements for Membership

Adjunct healthcare providers may enter the Academy at the Associate Member level. Additionally, one much possess a valid license or certificate appropriate for their profession that is not revoked or suspended unless retired 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 following pages.

Print legibly and fill in all applicable blanks. Return the completed form with the appropriate fee *(see chart below)* **to the AACP.** 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. 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.

Current Membership Dues

Join Between the Following Dates:		Associate Membership Dues
October 1–March 31	April 1–September 30	
$195.00 *full annual dues amount*	**$97.50** *half annual dues amount*	**$195.00** *billed annualy each September*

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

AACP Executive Office

12100 Sunset Hills Road | Suite 130
Reston, Virginia 20190

Phone 800.322.8651 | **Fax** 703.435.4390

Email central@aacfp.org

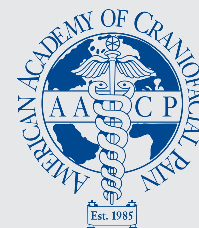
Website www.aacfp.org

Associate Membership Application

Instructions: *Please print legibly,* provide all applicable information requested below, and remit the appropriate dues amount. Please make check payable to AACP in *U.S. dollars* drawn on a *U.S. bank* or you may submit a VISA/MasterCard payment using the form on the following page.

Return to AACP via fax, mail, or email *(see number and address on the previous page)*.

leading the **TMD and Dental Sleep Community**



1. Full Name ______________________________ Date of Birth __________

(First/MI/Last/Designation, exactly as it should appear on official correspondence, certificates, etc.)

2. Mailing Address and Contact Information:

	OFFICE		HOME	
COMPANY NAME				
STREET ADDRESS				
CITY/STATE/POSTAL CODE				
COUNTRY				
PHONE | FAX (office and home)	PHONE	FAX	PHONE	FAX
EMAIL ADDRESS				
WEBSITE ADDRESS				

3. Education:

INSTITUTION	LOCATION	DEGREE	DATE RECEIVED

4. Name of the school from which you graduated ______________________________

5. 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.)*

6. Healthcare profession in which you are licensed to practice ______________________________

7. State/province/country in which you are licensed to practice ______________________________

8. 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.)*

9. 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. ***See AACP Code of Ethics and Bylaws (Attach a statement of explanation.)***

10. Is your practice a specialty or limited practice? ***(check one please)***

☐ ***No*** ☐ **Yes** *(If Yes, please list)* ______________________________

11. What percentage of your current practice involves Craniofacial Pain/TMD? ________ %

12. How did you hear about AACP or who recommended that you apply for membership? ______________________________

Application continued on next page

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 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 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 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 ________

Check One: ☐ **I DO**
☐ **I DO NOT** give permission to AACP to contact me (initial here ____________)

Preferred Method of Contact:
☐ Fax ☐ Phone ☐ Email ☐ Postal Mail

Please submit your completed application FORM, along with the appropriate DUES amount to the AACP representative via:

FAX 703.435.4390 | **EMAIL** central@aacfp.org
Or **MAIL** 12100 Sunset Hills Road | Suite 130 | Reston, Virginia 20190

Method of Payment:

☐ **Check** *(Checks may be made payable to the AACP and must be in U.S. dollars drawn on a U.S. bank)*

☐ **Credit Card** ☐ 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 ____________ Accepted ☐ Yes ☐ No