

PCSP Application Form for Associate Membership

Name: _____ Email: _____

DOB: _____

Cell Phone: _____ Office Phone: _____

Residential Address: _____

Office Address: _____

Type of Practice: Number of Years: _____ Days/Week: _____

Dental Degree: _____ Year: _____ School: _____

Residency Education Specialty: _____ Graduation Year: _____

School: _____ MS Certificate

Subject/Title of Thesis: _____

1. Academic Teaching -

University:

Academic Rank:

Teaching Commitment: _____ % Research Commitment: _____ % Leadership Commitment: _____ %

2. Continuing Dental Education Teaching - Days/Year: _____

Study Club Leader - Days/Year: _____

3. Number of Articles Published: _____ Articles submitted but pending: _____

4. Presentation to PCSP - Date: _____
Title: _____

5. Sent Manuscript Sent to PCSP: Y N Date: _____

Journal Name Submitted: Y N Date: _____

Manuscript Published:

6. First Nominator:

Letter Sent: Y N

Second Nominator:

Letter Sent: Y N

FOR SECRETARY AND MEMBERSHIP COMMITTEE USE ONLY

Check list: Presentation Manuscript Curriculum Vitae Photograph Biography

Presentation Evaluation:

First Nominator: Letter Received: Y N

Second Nominator: Letter Received: Y N