APPLICATION FOR CERTIFICATION EXAMINATION BY THE AMERICAN ASSOCIATION OF DENTAL CONSULTANTS

Application must be submitted no less than 60 days prior to exam

Name: _____ Degree(s): _____

Office Address: _____

Home Address: _____

Office Phone: _____ Home Phone: _____

E-mail: _____

State or Province in which you practice: _____

Dental License Number: _____

Article was published in BEACON issue and year _____

OR

The date and who approved the Beacon Article (or summary) _____

_____

Name of active Certified Dental Consultant of AADC who is sponsoring your certification:

Name: _____ E-mail: _____

Or Telephone: _____

Requirements that must be completed prior to submitting application:

- ❑ Have an active dental license
- ❑ Have at least five years' experience in the clinical practice of dentistry.
- ❑ Have been retained, employed, or working in the dental benefits industry for a minimum of three years.
- ❑ Attend two of the three AADC Spring Workshop previous to the year of taking the examination.
- ❑ Have an article published or approved for publication in The Beacon.
- ❑ Complete and return the CDC application form with the required fees to the AADC Central Office.

Note: In May 2016 the AADC Board of Directors defined "Attendance of AADC Workshop" as requiring presence for at least two days of a Workshop.

List attendance at AADC workshops: _____

Are you currently an active member of the American Association of Dental Consultants? [ ] Yes [ ] No

Date you became a member: _____

List AADC committees on which you have served: _____

_____

Member of:

American Dental Association: [ ] No [ ] Yes from _____ to _____

State or Province Dental Society: [ ] No [ ] Yes from _____ to _____

County or District Dental Society: [ ] No [ ] Yes from _____ to _____

Dental School Attended: _____

Year of Graduation: _____

Residency(ies): _____

Location: _____

Specialty Practiced: _____ Years in Practice: _____

Board Certified: [ ] Yes / [ ] No

List Committee experience in organized dentistry: _____

_____

How is your professional time spent?

Dental Benefits Industry _____ %

Private Practice _____ %

Teaching _____ %

Hospital _____ %

Other _____ % define: _____

Current Dental School Faculty Appointment:

School: _____

Title: _____ Dates _____

Previous Teaching Appointments:

School: _____

Title: _____ Dates _____

List experience in clinical practice of dentistry including dates, location and nature of practice:

_____

_____

_____

_____

List dates of employment in Dental Benefits Industry:

Name of Company	Capacity	Dates Employed or Retained

List any Federal, State, Province or Local Organizations, committees or activities to third party dental programs in which you have served. Include capacity and years:

_____

_____

_____

If you have a separately prepared curriculum vitae and a list of your personal publications, other society memberships, or other professional activities and achievements, please attach a copy to application.

FEE APPLICATION FOR CERTIFICATION EXAMINATION BY THE AMERICAN ASSOCIATION OF DENTAL CONSULTANTS

Name: _____

Billing Address: _____

Fee Enclosed: [ ] Member ($450.00) [ ] Non-member ($900.00)

[ ] Check **Make Check Payable to:** American Association of Dental Consultants

[ ] VISA [ ] MASTERCARD [ ] AMEX [ ] DISCOVER

Credit Card Number:_____ Expiration:_____

Security Code:_____ Signature*:_____

**I understand that this fee will b returned less $50.00 for processing, if ineligible to sit for exam.*

Mail Application and Payment to: AADC, 1971 Chesterfield Ridge Circle, Chesterfield, MO 63017

Or **Fax:** 636.591.0616 *or* **Email:** ellen@aadc.org

Note: Once all requirements are fulfilled and verified you will be notified within three (3) weeks, via email, of your acceptance or denial to take the exam after submission of this application.