



Phone: 888.243.3368, ext. 4969  
 Fax: 312.335.3428  
 www.agd.org

# 2018 MASTERSHIP AWARD APPLICATION

Application must be postmarked by Dec. 31, 2017

\_\_\_\_\_  
 Last name First name Middle initial Degree

\_\_\_\_\_  
 Street address City State/province ZIP/postal code Country

\_\_\_\_\_  
 Phone Fax Email

\_\_\_\_\_  
 Dental school Graduation year / /

\_\_\_\_\_  
 AGD ID number Date Fellowship was obtained

\_\_\_\_\_  
 State/province where licensed License number Military branch (if applicable)

My check in the amount of \$770, payable to the AGD in U.S. dollars, is enclosed. There will be a \$25 fee for all returned checks.  
**OR**  
 Charge my  Visa  MasterCard for \$770.

\_\_\_\_\_  
 Card number Exp. date Name as it appears on card

\_\_\_\_\_  
 Signature (required to process your application)

I affirm that the attached Mastership Award application accurately itemizes my AGD-acceptable Mastership credits. I understand that the AGD will check the accuracy of the credits listed. *I also understand that I am responsible for the completeness and accuracy of the credit information attached and that the AGD is not responsible for any errors or omissions in my computer record.* I agree to abide by the decision of the Dental Education Council and the Board of Trustees regarding whether or not I meet the requirements for Mastership. I do hereby attest that my privilege to practice dentistry has not been suspended or revoked in the past five years and is not currently under consideration for suspension or revocation, and that I am currently in good standing with my local state board of dentistry. I also attest that I have paid my AGD membership dues and I am currently in good standing with the AGD. I understand that inaccurate information can result in permanent ineligibility to receive the Mastership Award and that such decisions made by the Dental Education Council are final. **Applications withdrawn after the Dec. 31, 2017, deadline or determined by the council not to meet the Mastership requirements are subject to a processing fee of \$100 (U.S.).**

\_\_\_\_\_  
 Date Signature

**IMPORTANT CONVOCATION INFORMATION**

**Please note:** Submitting this information does not guarantee that your application will be approved by the Dental Education Council or the Board of Trustees.

I plan on attending the 2018 Convocation Ceremony in New Orleans on Saturday, June 9, 2018.

**Plaque:** This is how I would like my name to appear on my award plaque: \_\_\_\_\_  
 Please print clearly

**Mail checks to:**  
 Academy of General Dentistry  
 28148 Network Place  
 Chicago, IL 60673-1281

**Mail credit card payment to:**  
 Academy of General Dentistry  
 560 W. Lake St., Sixth Floor  
 Chicago, IL 60661-6600

**Fax credit card payment to:**  
 312.335.3428  
**Phone:** 888.AGD.DENT (888.243.3368)