

Application for Membership

Type of membership: Ordinary / Associate / Student (Please delete accordingly)

Entrance fee: \$50.00
 Annual subscriptions
 - Ordinary member: \$100.00
 - Associate/Student member: \$50.00

Designation: _____ DCR: _____ Name: _____

Office address: _____

Office phone no.: _____

Mailing address: _____

Mobile number: _____ Email address: _____

Qualifications (Please indicate year, and submit copy(s) of all periodontal certification):

Practice Information (Please ✓ as appropriate):

	Full-Time	Part-Time
Private clinic	_____	_____
Teaching (Tertiary education)	_____	_____
Government/Public service	_____	_____
Military Service	_____	_____
Limited to Periodontics	Yes: _____	No: _____

Proposer: _____ Second: _____

Signature: _____ Signature: _____

For Official Use -

Approved for Membership: Yes / No. Date Received: _____
 Entrance fee received: Yes / No. Date of approval: _____
Subscription fee received: Yes / No. \$ _____