



The Canadian Academy of Restorative Dentistry and Prosthodontics
L'Académie Canadienne de Dentisterie Restauratrice et de Prosthodontie



(APPLICATION FOR MEMBERSHIP – FACULTY MEMBER)

Date: _____ Date Received by Admissions Chair: _____

Applicant's Complete Name: _____ Proposer's Name: _____

Applicant's Preferred Name: _____ Secondary Proposer's Name: _____

Year of Dental Graduation: _____

Applicant's Business Address: _____ Bus. Phone: _____

_____ Home Phone: _____

_____ Fax No.: _____

_____ E-Mail: _____

Degree(s), School (s) and Year(s) Obtained: _____

Number of Years in Practice: _____ G.P. or Specialist (list specialty): _____

Other Memberships, Qualifications or History: _____

Teaching Experience or Presentations Given: (list additional on reverse if more space required)

Publications (list most pertinent if any): _____

Number of CARDP Meetings Attended (indicate which years): _____

Proposer's Signature: _____

Secondary Proposer's Signature: _____

Submit form to Dr. Jay McMullan @ drjay@videotron.ca

Or David Alexander @ info@cardp.ca

