AADSM
2510 North Frontage Rd.
Darien, IL 60561
Phone: 630-737-9705 Fax: 630-737-9790

Accreditation No._____
For office use only

Application Fee Form

Please complete and submit this form along with the *Accreditation Application* to the AADSM National Office.

Name of DSM Facility: _____

Name of Dental Director: _____

Address: _____

City: _____ State: _____ Zip/Postal Code: _____

Phone: _____ Fax: _____

Name of Primary Contact: _____

Email Address of Primary Contact: _____

Please select the appropriate application fee:

☐ AADSM Member: $2,500.00 (AADSM Member Number: _____)
☐ Nonmember: $2,675.00

Method of Payment ***(please check one)***

☐ Please make checks payable to the AADSM (U.S. funds drawn on a U.S. bank)
☐ For payment by credit card (Visa/Mastercard/American Express):

Credit Card Number: _____

Expiration Date: _____/_____ Validation code*: _____

Cardholder's Name: _____

Billing Address: _____

Signature: _____ Date: _____/_____

**For a VISA or MasterCard, the validation code is the last 3 numbers in the signature box. For an American Express, the validation code is the 4 numbers above the credit card number.*