AMERICAN ACADEMY OF DENTAL SLEEP MEDICINE

2025 Application for Student Membership

Visit **aadsm.org/membership** for a description of the AADSM Student membership category.
Students must re-apply on a yearly basis. Please print clearly or type information.

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E: info@aadsm.org
www.aadsm.org

Biographical Information

Name: (Last)		(First)	(Middle)
Home Address:		City:	
State:	Postal Code:	Country:	Mobile:
Fax:	Email*:		

*Email addresses will be used to provide members with information about the AADSM and industry news and events.

Current Educational Program/School Address

Institution/School Name:			
Address:			
City:	State:	Postal Code:	Country:
Phone:	Fax:	Website:	
Start Date:	Projected End Date:		

Degree in Progress (Select the degree that will be obtained upon completion of the program above.)

O DDS	O DMD	O MD	O PhD
O DO	O Other equivalent degree:		

Program type: (Please check one.)

O Endodontics	O General Dentistry	O Oral & Maxillofacial Surgery	O Orthodontics
O Pediatric Dentistry	O Periodontology	O Prosthodontics	O Other:

Highest Degree Obtained to Date

Institution/School Name:		Degree: O **BA/BS** or O **Advanced Degree:**	
Graduation Date:		Address:	
City:	State:	Postal Code:	Country:
Phone:	Fax:		

Program Enrollment Verification

IMPORTANT: This section must be completed before your application can be processed. This is to verify that the above person is currently enrolled full-time in the above advanced educational program

Registrar or Program Director Signature:	Date:
Name:	Title:
Phone:	Email:
Applicant Signature:	Date: