International Dental Implant Association
Fellowship Application

NAME *(As you wish it to appear on membership certificate)*

First _____ Initial(s)_____ Last _____

Degree(s) _____,_____,_____

Delivery of Certificate ☐ By Mail ☐ At the Annual Meeting ☐ At an Implant Seminars Course

ADDRESS

Practice/Business Name _____

Address _____ Suite _____

City _____ State _____ Zip _____

Office Telephone _____ Office Fax _____

Cell Phone _____ E-Mail Address(s) _____

Web Site _____

Best Time to Contact:_____

CONTINUING EDUCATION AND TRAINING

Course Name _____ CE Hours _____ Year _____

Course Name _____ CE Hours _____ Year _____

Course Name _____ CE Hours _____ Year _____

IMPLANT DENTISTRY EXPERIENCE

Implant Continuing Education Hours in last 3 Years _____

Experience in Implant Dentistry: ☐ less than 10 cases ☐ 10-49 cases ☐ 50-100 cases ☐ more than 100 cases

International Dental Implant Association
Fellowship Application

Member ID# _____

FELLOWSHIP

One-time processing fee $700

PAYMENT INFORMATION

Return this application with your membership dues to:

The International Dental Implant Association
17501 Biscayne Blvd.
Suite 600
North Miami Beach, FL 33160
305.945.7334

Checks: Please make payable to The International Dental Implant Association and send to the above address.

Or fax: 1.305.397.2830

Or email: admin@internationaldentalimplantassociation.com

Credit Cards: Please complete the following information

☐ MasterCard ☐ Visa ☐ American Express ☐ Discover

Name on Card _____

Card # _____

Exp. Date _____ CVV# _____

Billing Zip Code _____

Signature _____ Date _____