



**AMERICAN ACADEMY OF DENTAL SLEEP MEDICINE**  
**2022 Application for Student Membership**

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Visit [aadsm.org/membership](http://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.

**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.)

<input type="radio"/> DDS	<input type="radio"/> DMD	<input type="radio"/> MD	<input type="radio"/> PhD
<input type="radio"/> DO	<input type="radio"/> Other equivalent degree:		
Program type: (Please check one.)			
<input type="radio"/> Endodontics	<input type="radio"/> General Dentistry	<input type="radio"/> Oral & Maxillofacial Surgery	<input type="radio"/> Orthodontics
<input type="radio"/> Pediatric Dentistry	<input type="radio"/> Periodontology	<input type="radio"/> Prosthodontics	<input type="radio"/> Other:

**Highest Degree Obtained to Date**

Institution/School Name:		Degree: <input type="radio"/> BA/BS or <input type="radio"/> Advanced Degree:	
Graduation Date:		Address:	
City:	State:	Postal Code:	Country:
Phone:	Fax:		

**Program Enrollment Verification**

<b>IMPORTANT:</b> 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: