ASSOCIATE MEMBERSHIP APPLICATION
UNIVERSITY OF THE PACIFIC
ARTHUR A. DUGONI SCHOOL OF DENTISTRY
ALUMNI ASSOCIATION

NAME:_____ _____
Last First Initial Degree(s)

Preferred First Name:_____ License #:_____

Dental School:_____ Class year:_____

Specialty:_____ Board Certified?:_____

Office Address:_____

Home Address:_____ Phone: _____

Office Phone:_____ Office Fax:_____
Include area code

Email address:_____ Spouse:_____

Mail preferred at: _____ Office _____ Home

Enclose with $195.00 for 2009 Dues
Return form in enclosed envelope with check made payable to Pacific Alumni Association
or
complete credit card information and fax form to (415) 749-3377.

AmEX, Visa or MasterCard #_____ Expiration date:_____

Signature:_____ Billing address & zip code:_____

AssociateMembershipApplication