

**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 \$175.00 for 2008 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: _____