

**The Association of Consultants and Specialists in Restorative Dentistry
Membership application form**

Please use capital letters

NAME:.....TITLE.....

DEGREES:

YEAR OF (primary) QUALIFICATION:

D.O.B:

HOME ADDRESS:.....

.....

.....

TEL:

MAIN BASE/PRACTICE:

.....

.....

TEL:FAX:.....EMAIL.....

OTHER CENTRES:

.....

.....

MEMBERSHIP CATEGORY: FULL TRAINEE

(please circle one)

if TRAINEE, please indicate expected date of accreditation.....

SPECIALITY: RESTORATIVE, ENDODONTICS, PERIODONTICS, PROSTHODONTICS
(circle all that apply) SURGICAL DENTISTRY

if Consultant, : HONORARY OR NHS APPOINTMENT..... W.T.E.....

YEAR APPOINTED CONSULTANT and/or DATE OF ENTRY ON SPECIALIST REGISTER :

.....

Please return form to :- Dr D Bartlett, Hon Secretary ACSRD
Department of Prosthodontics
King's College London Dental Institute
Guy's Tower
London Bridge, SE1 9RT

With a cheque for £20.00, the subscription for 2005/2006.