RD-UK

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)

if Consultant,:HONORARY OR NHS
APPOINTMENT..W.T.E.......................
YEAR APPOINTED CONSULTANT and/or DATE OF ENTRY ON SPECIALIST REGISTER :……….
……
…..

Please return form to:-

Mr Martin Ashley, Hon Treasurer, ACSRD
Department of Restorative Dentistry,
University Dental Hospital of Manchester
Higher Cambridge Street
Manchester
M15 6FH

With a cheque for £40.00, the subscription for 2014-15.