

**CALIFORNIA SOCIETY OF PEDIATRIC DENTISTRY  
POSTDOCTORAL STUDENT APPLICATION**

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date of Application

Name (Last)	(First)	(MI)	Date of Birth / /		e-mail address @	
School Street Address		City	State	Zip	Telephone	Fax
Home	Street Address		City	State	Zip	Telephone
						List home phone in Directory? Yes ____ No ____
Spouse Name		List Spouse in Directory? Yes ____ No ____		Preferred CSPD Mailing Address school ____ residence ____ (residence suggested)		

**PROFESSIONAL TRAINING (List Month & Year)**

Institution	Undergraduate School		Dental School		Intern/Residency		Degree/Certificate
	From	To	From	To	From	To	

**HISTORY OF EXCLUSIVE PRACTICE, TEACHING OR RESEARCH IN DENTISTRY**

Dates		Place	Practice %	Teaching %`	Research %
From	To				

For pediatric residents CSPD requires membership in the American Academy of Pediatric Dentistry. This implies that you are an applicant or student member member of AAPD.  
I satisfy the requirements of membership. \_\_\_\_ Yes / No \_\_\_\_

Mail to:  
CSPD  
P.O. Box 221608  
Carmel, CA 93922

Application Fee:     \$0  
First Year Dues:     \$0