AMERICAN COLLEGE OF PROSTHODONTISTS
Your smile. Our specialty.®

# 2019 Membership Dues Installment Payment Authorization Form

## MEMBER INFORMATION

First Name | Middle Initial | Last Name

Phone

Email (required for communication purposes)

## MEMBER'S AUTHORIZATION

By signing this form, I authorize the American College of Prosthodontists to charge my credit card for three installment payments for my ACP membership dues including the additional three dollar ($3.00) processing fee per payment. I understand that the charges will be automatically processed on the following dates:

- January 31
- February 28
- March 29

Member Signature | Date

## MEMBER INFORMATION

☐ MasterCard ☐ Visa ☐ American Express

Cardholder Name

Credit Card Number | Exp. Date

Signature

Mail or fax your installment authorization form to:

American College of Prosthodontists
211 East Chicago Avenue, Suite 1000
Chicago, IL 60611
Phone: (312) 573-1260
Fax: (312) 573-1257