Membership Application

International Membership

Last Name / Surname ______________________ Date of Birth ______ / ______ / ______ ☐ Male ☐ Female
(mm / dd / yy)

First ______________________ Middle Name/Initial(s) __________ Degrees ______________

Practice/Business Name ____

Office Address ______________________________________ Suite ______________

City/Province ______________________ State __________ Country ____________ Postal Code __________

Telephone ____________________ Fax ____________________ E-mail ____________________

Web Address ____

Specialty ____

License # ______________________ Country of Licensure ______________________

☐ Generalist ☐ Oral & Maxillofacial Surgeon ☐ Periodontist ☐ Prosthodontist ☐ Endodontist

☐ Lab Technician ☐ Industry Personnel ☐ Military Personnel ☐ Full-Time Faculty Member

International Membership Dues *Valid for 12 months*

International dues vary from country to country, depending on economic conditions.
For specific dues information, please E-mail the ICOI Central Office at ***membership@icoi.org***

☐ Dentist: $275 ☐ Full-Time Faculty: $150 (please attach copy of ID) ☐ Laboratory Technician: $150

Dues Amount: $ ______________

Name of Affiliate Society (if applicable): ____

Payment Information

☐ MasterCard ☐ Visa ☐ American Express

We accept MasterCard, Visa and American Express payments via facsimile. Please complete the following and fax this form to: **973-783-1175**.

Card # ______________________________ Exp. Date ______________ CVV # ______________

Signature ____

You may also send payment in U.S. dollars on an international money order, a postal money order or a check drawn on a U.S. bank.

RETURN THIS APPLICATION WITH YOUR MEMBERSHIP DUES TO THE ICOI CENTRAL OFFICE

One Bridge Plaza N, Suite 950, Fort Lee, NJ 07024 • Phone: 973-783-6300 / 800-442-0525 • Fax: 973-783-1175
membership@icoi.org • Visit www.icoi.org for complete information