



GCOI MEMBERSHIP FORM

First Name: _____ Middle name: _____ Last name: _____

Preferred name: _____

(As you wish to appear on certificates, directories, etc)

Date of Birth: _____ Gender: _____ Citizenship: _____

Contact Information: _____

Mailing Address: _____

City: _____ State/Province: _____ Postal code: _____

Phone Number: _____ Email address: _____

Educational Background: _____

Dental school Degree(s): _____ Date of Graduation: _____

Postgraduate Education (List relevant programs and institutions): _____

Years of clinical experience in dentistry: _____ Years of experience in oral implantology: _____

Current practice type (Solo,group,academic,etc): _____

Professional website or online presence(URL): _____

Country of Licensure: _____ License #: _____

Speciality: _____ AGD #: _____

Membership category(Please select one):



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Active member:

(Open to dentists practising oral implantology)

Affiliate member:

(Open to dental professionals involved in implantology but not actively practising dentistry)

Student member:

(Open to currently enrolled dental students)

Professional Affiliations:(List relevant professional organisations and memberships)

References: (Please provide contact information for two professional references)

Reference 1: _____

Reference 2: _____

(Name, Title, Affiliation, Email Address)

Dues and payment: Please visit our website or contact the GCOI office for current membership dues, information and payment options. <https://www.globalcoi.com/>

Declaration:

I understand and agree to abide by the bylaws and code of ethics of the Global College of Oral Implantology, I declare that the information provided in this application is accurate and complete to the best of my knowledge

Signature: _____

Date: _____

Please submit your completed application electronically to (email address) or by mail to mail@globalcoi.com

Thank you for your application! We look forward to welcoming you to the GCOI community.