AACD Poster Competition Submission Form

*This form MUST accompany ALL poster submissions**

First Name | Middle | Last Name | Designation/Degree

Dental School

Personal Mailing Address | City, State, Zip

Country

E-mail Address: | Mobile Phone Number

Please check the applicable boxes	☐ Student	☐ Recent Graduate		☐ Male	☐ Female

Poster Title

Poster Category (Please check **ONE**)

Undergraduate Clinical Case ☐

Undergraduate Materials Science ☐

Post Graduate Clinical Case ☐

Post Graduate Materials Science ☐

Co-Author(s):

By signing below, I attest that all information provided in word or image is either my own, or credited to the appropriate party(ies).

*** All poster submissions must be reviewed, and signed off by a Faculty at your University
*** AACD Membership is required for all posters selected for the poster competition / or display only.
Click Here to Join AACD

Student Signature

Date

Faculty Signature

Please print Faculty name

Date

**** If this form is not filled out completely and signed, the poster will be disqualified***