AACD Poster Competition Submission Form

*This form MUST accompany ALL poster submissions**

First Name | Middle | Last Name | Designation/Degree

Dental School

Personal Address | City, State, Zip

Country

E-mail Address: | Mobile Phone Number

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

Poster Title

Poster Category (Please check **ONE**)

- Undergraduate Clinical Case Award ☐
- Undergraduate Materials Study Award ☐
- Post Graduate Clinical Case Award ☐
- Post Graduate Materials Study Award ☐
- Junior Faculty Clinical Case Award ☐
- Junior Faculty Materials Study Award ☐

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).

Signature

Date

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