



## Friends of the National Institute of Dental and Craniofacial Research

1901 Pennsylvania Avenue, NW

Suite 607

Washington, DC 20006

**Phone:** 202.223.0667

**Fax:** 202.463.1257

[www.FNIDCR.org](http://www.FNIDCR.org)

# Membership Application

### **Membership Category** *(please check one)*

Corporation  Patient Advocacy Organization  Academic Institution  Non Profit Organization  Individual

### **Your Information**

Organization Name: \_\_\_\_\_

Contact Name: \_\_\_\_\_ Title: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Email Address: \_\_\_\_\_

Web Address: \_\_\_\_\_

### **Membership Levels** *(please check one)*

#### **Corporation**

Platinum (\$10,000+)  Gold (\$5,000)  Silver (\$2,500)  Bronze (\$1,000)  Donor \$\_\_\_\_\_

#### **Academic Institution & Non Profit Organization**

Platinum (\$5,000+)  Gold (\$3,000)  Silver (\$2,000)  Bronze (\$1,000)  Donor \$\_\_\_\_\_

#### **Patient Advocacy Organization**

Platinum (\$1,000+)  Gold (\$500)  Silver (\$250)  Bronze (\$150)  Donor \$\_\_\_\_\_

#### **Individual**

Platinum (\$5,000+)  Gold (\$2,500)  Silver (\$1,000)  Bronze (\$500)  Donor \$\_\_\_\_\_

### **Payment Information**

**CHECK: Please send your check payable to FNIDCR with this completed form to:**

FNIDCR, 1901 Pennsylvania Avenue NW, Suite 607, Washington DC 20006

**CREDIT CARD: Fax this form with credit card payment to 202-463-1257**

Card Info:  Visa  MC  AMEX Exp. Date (mo/yr) \_\_\_/\_\_\_ Card Number: \_\_\_\_\_

Cardholder's signature \_\_\_\_\_ Cardholder's name on card (print) \_\_\_\_\_

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Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### **For More Information:**

Contact Peter Anas, Executive Director, at 202.223.0667 or [peter@fnidcr.org](mailto:peter@fnidcr.org).