



Institutional Membership Application Form
South East Asia Association For Dental Education

Name of Dental School : _____

Address : _____

State : _____

Country : _____ Postal Code : _____

Telephone Number : _____ Fax Number : _____

Internet Website : _____ E-mail Address : _____

Type (e.g. Private, Government, etc) : _____

Degrees Awarded : _____

Length of Undergraduate Course : _____

Types and Length of Postgraduate Courses : _____

Number of Students Admitted per year for each course : _____

Number of Academic Staff : _____ (Full Time Staff) _____ (Part Time Staff)

Please put a tick in the box applicable to you:

New Membership

Membership Renewal

Attached is :

Institutional Membership Fee for 2 years of USD 200 cash/bank draft No. : _____

made payable to "SEAADE 95", to be drawn in a Singapore Bank. Please address all payments to
Assoc Prof Leung Wai Keung, Hon Treasurer SEAADE, c/o Faculty of Dentistry, University of
Hong Kong, Prince Philip Hospital, 34 Hospital Road, Hong Kong . FAX : 852 2517 0544

Signature : _____

Date : _____

Name and Title : _____

