Membership Dues Support Program
For Financial Assistance

June 1, 2025 — May 31, 2026

RETURN FULLY COMPLETED

By email: member@oda.ca
or
By mail: Membership Administration, Ontario Dental Association
4 New Street, Toronto, Ontario M5R 1P6
Tel: 416-922-3900 • Toll Free: 1-800-387-1393

The ODA recognizes that members, from time to time, encounter periods of hardship. We have developed the ODA Membership Dues Support Program to assist during these times.

Full disclosure and submission of pertinent information will be required with one's application. This Program will be limited to three (3) years lifetime, subject to the discretion of the Chair, Membership Services and Programs Advisory Committee. Dues under this program for 2025/2026 range from $536.75 (includes $61.75 HST) to $1,192.15 (includes $137.15 HST), depending on one's circumstance. Acceptance shall be at the discretion of the Chairman and one other member of the Membership Services and Programs Advisory Committee, following receipt and assessment of the member's application, and supporting financial and other information.

The information provided is strictly confidential and will not be shared or recorded in your member profile.

APPLICANTS PLEASE COMPLETE ALL THE INFORMATION ON THIS FORM

Membership ID #: _____ Dr. _____

Practice Name: _____

◯ Home ◯ Office

Address: _____

City: _____ Province: _____ Postal Code: _____

Phone: _____ ◯ Home ◯ Office

My estimated net income including all sources for my last fiscal year before May 31, 2025 is $ _____ plus disability insurance income of $ _____ , if applicable.

My anticipated net income for my next fiscal year before May 31, 2026 or during the membership year June 1, 2025 to May 31, 2026 is $ _____ plus disability insurance income of $ _____ , if applicable.

Attached is a copy of my income and expenses filed with Canada Revenue Agency (CRA) and a copy of my notice of assessment.

Attached is a copy of my disability income insurance statement in support of this information.

Please note: additional information may be required.

ADDITIONAL INFORMATION FOR COMMITTEE APPROVAL:

Outlined below are my reason(s) for applying for this Program, including an explanation of my circumstances:

I certify the information supplied above is accurate to the best of my knowledge and understand that additional information may be required before final approval of this application. I also understand that all information supplied will be held in strict confidence, and used only by the Membership Services and Programs Advisory Committee to determine final approval of my membership status.

Signature: _____ Date: _____

FOR ODA USE ONLY

Approved by: _____ Date: _____

Approved by: _____ Date: _____ Amount Approved: $ _____

HST#: 108090945RT0001

Privacy: The information collected on this form will be used by the ODA for the purpose of processing your membership and for no other purpose. The ODA is committed to protecting the privacy of your personal information. Our privacy policy and further information regarding the collection, use and disclosure of personal information can be viewed at www.oda.ca or by contacting our Privacy Officer: tel: 416-922-3900 or 1-800-387-1393; email: info@oda.ca.