

**June 1, 2026 - May 31, 2027**

Apply when you receive your Licence Registration Number

**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

**PLEASE PRINT CLEARLY**

First Name: \_\_\_\_\_ Middle Name: \_\_\_\_\_

Last Name: \_\_\_\_\_

Choose only one Preferred (can be any combination). The ODA's main method of communication with members will be through email.

**Office Address:** Preferred

Practice Name (if applicable): \_\_\_\_\_

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

City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Website: \_\_\_\_\_

Office Telephone Number: \_\_\_\_\_ Preferred Telephone Number

Office Fax Number: \_\_\_\_\_ Preferred Fax Number

Office Email Address\*: \_\_\_\_\_ Preferred Email Address

**Home Address:** Preferred address for mailing

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

City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Home Telephone Number\*: \_\_\_\_\_ Preferred Telephone Number

Home Fax Number: \_\_\_\_\_ Preferred Fax Number

Home Email Address\*: \_\_\_\_\_ Preferred Email Address

Male Female Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

RCDSO Certificate of Registration # \_\_\_\_\_ Date Received: \_\_\_\_/\_\_\_\_/\_\_\_\_

Specialty: \_\_\_\_\_

Name of University: \_\_\_\_\_ Country/Province: \_\_\_\_\_ Graduation Year: \_\_\_\_\_

If you did not attend an **Ontario University**, which of the following programs did you complete?

An Accredited Dental Program or Qualifying/Degree Completion Program

The NDEB Equivalency Process

Current ODA Student member: YES FROM: \_\_\_\_\_ TO: \_\_\_\_\_

NO

**PLEASE SEE PAGE TWO FOR INFORMATION**

**The following questions will help us serve you better and develop programs that matter. Collecting this information will help the ODA streamline communications to you.**

1. Which scenario describes your primary role in practice. Please select only one scenario:
  - A practice owner of 1 practice
  - A practice owner with 2 practices
  - A practice owner with 3+ practices
  - An associate working in 1 practice
  - An associate working in 2 practices
  - An associate working in 3+ practices
  - In a corporate practice as a principal contractor
  - In a corporate practice as an associate
  - Not in private practice (e.g. work in hospital, teaching facility, Canadian Forces, etc.)
  - Not currently practicing
  
2. Do you work in or do you provide dental care in a hospital setting?
  - Yes            No

**\*Please refer to “Your email address” in the ODA Privacy Statement.**

**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 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](http://www.oda.ca) or by contacting our Privacy Officer: Tel: 416-922-3900 or 1-800-387-1393; Email: [info@oda.ca](mailto:info@oda.ca).