**Armenian Canadian Dental Association of Ontario**

**Membership Application**

Title: Dr./ Mr./ Mrs./ Ms

First Name: …………………………………………………………………

Last Name: …………………………………………………………………

Date of Birth: -------------- / ------------- / ----------------

Occupation: ………………………………………………………………..

Degrees and Diplomas: ………………………………………………….......................................................... ........................................................................................................................................................................

Mailing Address: ……….…………………………………………………………………………………………… ………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………

Home Phone Number: …………………………….. Mobile Phone Number: …………………………..

E-mail: ………………………………………………………………………………….

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| Membership fee is $100 CAN for **regular members**. Reduced membership fee of $50 CAN for **students, residents, fellows and non-licensed professionals**.  Choose Payment Method:   * Cash * Cheque: Send a cheque to following Address:   *#305 – 1110 Sheppard Ave E. Toronto, ON, Canada, M2K 2W2*   * Credit Card: Visa / MasterCard / American Express   Card Number: ………………………………………………………….  Card Holder Name: ……………………………………………………………………….  Expire Date: ………/……… Security Number: ………………………………..  Note: A charitable donation receipt will be sent to your mailing address. |

I agree on becoming a member of Armenian Canadian Medical Association of Ontario and subscribe to ACMAO E-mail list.

Signature (or Initials): ……………………………………………. Date: ………………………………………