Armenian Canadian Dental Association of Ontario Membership Application

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

First Name: …………………………………………………………………

Last Name: …………………………………………………………………

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

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

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

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

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

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

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:

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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: ………………………………………