



APPLICATION FOR OWNER OR ASSOCIATE MEMBERSHIP

Section A: Facility Information

Owner, Operator	First Name	Middle Initial	Last Name
Name of Applicant	First Name	Middle Initial	Last Name
Clinic Address <i>(Please attach address list of all facility locations, if more than one)</i>	Street Address		Email
	City	Province	Postal Code
	Telephone	Facsimile	
Total Number of Employees			
Type of Services <i>(by facility if specific locations offer different services) :</i>			

Section B: Membership Information

Enclosed with my application is my membership fee in the amount of:

(Please check one of the appropriate boxes and attach address list of all facility locations)

- | | | | |
|-------------------|--------------------------|---------|--|
| Member: | <input type="checkbox"/> | \$350 | 1-2 Clinics |
| (Owner/Operator) | <input type="checkbox"/> | \$750 | 3-5 Clinics |
| | <input type="checkbox"/> | \$1,250 | 6-9 Clinics |
| | <input type="checkbox"/> | \$2,500 | 10-29 Clinics |
| | <input type="checkbox"/> | \$5,000 | 30+ Clinics |
| Associate Member: | <input type="checkbox"/> | \$50 | Member-Clinic Employee (e.g. Technologist) or Vendor |

I am available to participate on working committees of IDCA

Yes No

Section C: Payment Options

Members may complete this application providing VISA credit card information.

_____ (credit card nos)

_____ (name on the card)

_____ (expiry date)

- Either fax in this form using 905-707-0616 or email it to info@idca.ca. A receipt will be provided once payment is processed.
- Or, you may mail in this application with a cheque made out to the "IDCA". The mailing address is IDCA, 7330 Yonge St., Ste 120, Thornhill, ON, L4J 7Y7.

Section D: Signatory

Please sign and print your name clearly, along with your position and the date of application

_____ (Signature)

_____ (Please print Name)

_____ (Position)

_____ (Date)

FOR OFFICE USE ONLY: Date received: ____/____/____ Time Received ____:____ AM / PM