

Request for Waiver of Membership Dues

A full or partial waiver is available to a member in good standing whose circumstances have resulted in a significant financial hardship, including temporary or permanent disability, catastrophe, parental leave or medical illness.

1. All applicants should complete Section 1.
2. Applicants requesting a waiver due to Financial Hardship should complete Section 2, including the request for financial information.
3. Applicants requesting a waiver because of Financial Hardship due to Disability should have Section 3 completed by their physician.
4. Section 4 is to be completed by the constituent and component societies.

Please forward this completed form to your local society for their review and approval. They will send it to your state society for their review and the state society will forward it to the ADA.

Section 1 To be completed by the member dentist

Name	ADA ID Number	
Address		
City	State	Zip
I am requesting a waiver of dues from the American Dental Association and my constituent and component societies for the _____ membership year.		

Section 2 Financial Hardship Waiver (To be completed by the member dentist)

Please describe your financial situation and the reasons for your request for a financial dues waiver. Your local or state dental societies may request additional information in order to review your request. (This waiver may be requested by Humanitarian Practitioners.)

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Member's Signature	Date

Section 3 Financial Hardship Due to Disability Waiver

A Medical Certificate may be submitted to the constituent and component societies and is to be completed by your physician if your request is due to disability, which prevents you from engaging in the duties of the dental profession.

Federal Dental Service Dentists: A dentist who has been totally disabled during active military duty and who is unable to practice dentistry within the definition of the *Bylaws* and who was a member in good standing at the time total disability was incurred may be entitled to remission of dues upon certification by an agency of the federal government that the dentist is permanently and totally disabled in accordance with the standard schedule of rating disabilities in current use by the Department of Veterans Affairs.

Please describe the nature of disability

Approximate date incurred	Please check one: The disability is <input type="checkbox"/> Permanent <input type="checkbox"/> Temporary or unknown	
Attending Physician's Name	Attending Physician's Signature	
Attending Physician's Address	State	Zip

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Name	ADA ID Number
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Section 4 To be completed by the Constituent and Component Societies

Constituent Society Name	Component Society Name
Please check one: The waiver is granted <input type="checkbox"/> Humanitarian practitioner <input type="checkbox"/> For temporary financial hardship/disability <input type="checkbox"/> On a permanent basis due to financial hardship from permanent disability <input type="checkbox"/> Activated to federal service	Please check one: The above member has been approved for a: <input type="checkbox"/> Full Waiver (100%) <input type="checkbox"/> Partial Waiver (75%) <input type="checkbox"/> Partial Waiver (50%) <input type="checkbox"/> Partial Waiver (25%)
Constituent Society Executive Director	Date
Component Society Executive Director	Date

ADA Use Only

Member Year	Current Status
Approved	Letter Sent