



A full or partial waiver is available to a member in good standing whose circumstances have resulted in a severe 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 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 # _____

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.

Multiple horizontal lines for writing the financial hardship waiver details.

Member's Signature _____ Date _____

SECTION 3: DISABILITY WAIVER A Medical Certificate must be submitted to the constituent and component societies and is to be completed by your physician if your request is because of total disability, which prevents you from engaging in the duties of the dental profession. Attach documentation verifying your disability, which indicates whether it is permanent or temporary.

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 _____

Horizontal lines for describing the nature of disability.

Approximate date incurred _____

Please check one: The disability is: [] Permanent [] Temporary or unknown

Attending Physician's Signature

Attending Physician's Name and Address _____

Horizontal lines for attending physician's name and address.



Continued from front

SECTION 4: To Be Completed by the Constituent and Component Societies

Constituent Society Name

Component Society Name

Please check one: The request is due to: **Financial Hardship** **Disability**

Please check one: The waiver is granted: for 1 year due to financial hardship or temporary disability
 on a permanent basis due to permanent disability

Please check one: The above member has been approved for a: **Full Waiver (100%)**
 Partial Waiver (75%)
 Partial Waiver (25%)

Constituent Society Executive Director

Date

Component Society Executive Director

Date

ADA Use Only

Member Year _____

Current Status _____

Approved _____

Letter Sent _____