MASSACHUSETTS DENTAL SOCIETY

Two Willow Street
Southborough, Massachusetts 01745-1027
800.342.8747 • **massdental.org**

The Massachusetts Dental Society offers to waive membership dues for dentists who want to be members but find themselves in situations where it is difficult to afford the annual dues. Waivers are granted for reasons of financial hardship or disability. Requests and information provided are held strictly confidential and are reviewed anonymously by the Society's Waiver Review Committee. Personal identification (including name, address, ADA number, and district) is removed from the form before being reviewed by the committee.

Waiver applications must be legible, and typewritten is preferred. Please return your completed form by email (ccarter@massdental.org), or mail (Two Willow St, Southborough, MA 01745). The form may also be downloaded online at www.massdental.org/waiverform.

If you are applying for a financial hardship waiver, please complete the additional questionnaire and return it with your waiver form. If applying for a disability waiver, you should include a current letter from your physician detailing your disability and your potential return to work.

Thank you for your assistance and for taking the time to continue your membership. Your membership helps maintain the strength of the Society's to speak for and protect the interests of dentists. If you have any questions regarding dues waivers, please contact Christina Carter, Membership Administrative Assistant, at 800.342.8747 ext. 209 or by email at ccarter@massdental.org.

Request for Waiver of Membership Dues

ADA American Dental Association®
America's leading advocate for oral health

Department of Membership Information
211 East Chicago Avenue, Chicago, Illinois 60611
T 312.440.2699 F 312.440.2898 ADA.org

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 MDS-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. (This waiver may be requested by Humanitarian Practitioners.)

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 you 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 ☐ Permanent ☐ 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	MDS-ID

Section 4 To be completed by the Constituent and Component Societies

Constituent Society Name	Component Society Name
Massachusetts Dental Society	
Please check one: The waiver is granted ☐ Humanitarian practitioner ☐ For temporary financial hardship/disability ☐ On a permanent basis due to financial hardship from permanent disability ☐ Activated to federal service	Please check one: The above member has been approved for a: ☐ Full Waiver (100%) ☐ Partial Waiver (50%)

Constituent Society Executive Director	Date

Component Society Executive Director	Date

Below to Be Completed by MDS

Dental School Information:

Membership History:

Previous Waiver Request(s):

Current Dues Rate:

Other:

ADA Use Only

Member Year	Current Status
Approved	Letter Sent

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Financial Waiver Questionnaire

Please complete the following questionnaire if you are applying for a financial hardship and return with your request form. All information supplied to the MDS on this questionnaire will be kept strictly confidential.

If you have any questions, please contact Christina Carter, Membership Administrative Assistant, at 800-342-8747 extension 209 or ccarter@massdental.org.

1. Please explain your specific economic situation in detail as it relates to your waiver request. Please include whether or not you feel your situation is temporary or long term, any physical disability that may be affecting your earning potential, and what steps you have taken to mitigate your circumstances.

2. Outside of dentistry, do you have any additional sources (spousal income, investments?) Please explain.

3. Are you currently working? If so, please explain your situation.

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4. What type of plans do you think you will pursue in the future, and how does it relate to your waiver request? (i.e., owning a solo practice, taking 2-3 years off from dentistry to raise children, working as a dental administrator, working for a dental company as an employee?)

5. Do you have any outstanding loans from dental school or practice acquisition, etc? If yes, please specify and estimate monthly amounts:

	Yes/No	Est. Monthly Payment ($)
Undergraduate School	☐	.....
Dental School	☐	.....
Practice acquisition/equipment	☐	.....
Personal (credit cards)	☐	.....

Other(s):

_____

_____

_____

6. Additional Comments:

Thank you for your cooperation in completing this form. Please return with your waiver form to be processed confidentially.