

2022-2023 Clinic Membership Application

For the period September 1, 2022 to August 31, 2023

Date of Application _____
 Clinic Name _____
 Clinic Address _____
 City _____ Province _____ Postal Code _____
 Phone _____ Fax _____
 Clinic Administrator _____ Email _____

Indicate the total* number of DVMs that work in the clinic, as well as the number of clinics to be registered below.
 Please list DVMs and additional clinics on the reverse of this form.

***If you would like your Practice Manager to be a member, please circle in the section just below
 and add their name on the reverse of this form***

Number of DVMs	Fee	HST	Membership Fee
1	\$790.00	\$102.70	\$892.70
2	\$1,035.00	\$134.55	\$1,169.55
3	\$1,280.00	\$166.40	\$1,446.40
4	\$1,525.00	\$198.25	\$1,723.25
5	\$1,770.00	\$230.10	\$2,000.10
6	\$2,015.00	\$261.95	\$2,276.95
7	\$2,260.00	\$293.80	\$2,553.80
8 or more			Contact OVMA

Number of Additional Clinics	Fee	HST	Additional Membership Fee
0			\$0.00
1	\$200.00	\$26.00	\$226.00
2	\$400.00	\$52.00	\$452.00
3	\$600.00	\$78.00	\$678.00
4	\$800.00	\$104.00	\$904.00

Practice Manager as Member (Optional)	\$245.00	\$31.85	\$276.85
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***All DVMs in the practice must be included in the OVMA membership;
 includes owners, partners and associate DVMs employed full or part-time; does not include locums.**

Method of Payment

- Cheque Enclosed (*post-dated cheques are not accepted and will be returned*)
- Visa or MasterCard

Card #: _____ Expiry Date: _____ CVV: _____

Name as it appears on Credit Card: _____

Authorizing Signature: _____

1. Please list the DVMs working in the clinic.
2. Please indicate the Practice Manager if included in the Clinic Membership.

Remember to contact OVMA should a DVM leave or join the clinic during the membership year.

	First Name	Last Name	Email Address
Dr.			
Dr.			
Dr.			
Dr.			
Dr.			
Dr.			
Dr.			
Dr.			
Dr.			
Dr.			
PM			

Additional Clinic

If applying for a Clinic Membership for a second clinic, please provide the contact information below:

Clinic Name _____

Clinic Address _____

City _____ Province _____ Postal Code _____

Phone _____ Fax _____

Clinic Administrator _____ Email _____

1. Please list the DVMs working in the additional clinic.
2. Please indicate the Practice Manager if included in the Clinic Membership.

Remember to contact OVMA should a DVM leave or join the clinic during the membership year.

	First Name	Last Name	Email Address
Dr.			
Dr.			
Dr.			
Dr.			
Dr.			
Dr.			
Dr.			
Dr.			
Dr.			
Dr.			
PM			

NOTE: If submitting a Clinic Membership Renewal for more than two clinics, please contact OVMA at info@ovma.org or 1.800.670.1702.