

## **CDHA EDUCATOR INSTITUTIONAL MEMBERSHIP**

Institution:		
Institution Address:		
Primary Contact Name:		
Phone Number:	Email address:	
Please note that individuals listed $\boldsymbol{\iota}$	the number of educators enrolled under your institution. Inder your institution must be dental hygienists and CDHA o CDHA's Educator benefits. Please select the appropriate ing:	
\$100 flat rate for 3-5 Dental	Hygiene Educators	
\$200 flat rate for 6-15 Denta	l Hygiene Educators	
\$400 flat rate for 16+ Dental	Hygiene Educators	
Educator Information:		
Educator #1 Name:	CDHA Number:	
Email address:		
	CDHA Number:	
Email address:		
Educator #3 Name:	CDHA Number:	
Email address:		
Educator #4		
Name:	CDHA Number:	
Email address:		

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Educator #5	
Name:	CDHA Number:
Email address:	
Educator #6	
Name:	CDHA Number:
Email address:	
Educator #7	
Name:	CDHA Number:
Email address:	
Educator #8	
Name:	CDHA Number:
Email address:	
Educator #9	
Name:	CDHA Number:
Email address:	
Educator #10	
Name:	CDHA Number:
Email address:	
(see following page for additional educator fields)	
Payment Information	
Total:	
Payment Type: Credit Card (Visa/MC)	Cheque
Credit Card Number:	
Expiry Date (MM/YY):	
Name on Card:	
<b>NOTE</b> : Membership fees are non-refund	able, non-transferable and are not prorated.

Please return completed form and payment to CDHA by email, fax or mail:

Email <u>info@cdha.ca</u> Fax 613-224-7283

Mail 1122 Wellington St. W, Ottawa ON, K1Y 2Y7

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Educator #	
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