ONTARIO VETERINARY MEDICAL ASSOCIATION

205-420 Bronte St S Milton, ON L9T 0H9
T. 905.875.0756 or 1.800.670.1702 (toll free)
F. 905.875.0958 or 1.877.482.9541 (toll free)
info@ovma.org www.ovma.org

2024-2025 Clinic Membership Application

****For the period September 1, 2024 to August 31, 2025****

Clinic Name _____

Clinic Address _____

City _____ Province _____ Postal Code _____

Phone _____ Fax _____

Clinic Administrator _____ Email Address _____

Indicate the total* number of DVMs that work in the clinic(s), 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 indicate in the Optional section just below and add their name on the reverse of this form.

Number of DVMs	Fee	HST	Membership Fee
☐ 1	$840.00	$109.20	$949.20
☐ 2	$1,100.00	$143.00	$1,243.00
☐ 3	$1,360.00	$176.80	$1,536.80
☐ 4	$1,620.00	$210.60	$1,830.60
☐ 5	$1,880.00	$244.40	$2,124.40
☐ 6	$2,140.00	$278.20	$2,418.20
☐ 7	$2,400.00	$312.00	$2,712.00
☐ 8 or more	Contact OVMA		
Number of Additional Clinics	**Fee**	**HST**	**Additional Membership Fee**
☐ 1	$210.00	$27.30	$237.30
☐ 2	$420.00	$54.60	$474.60
☐ 3	$630.00	$81.90	$711.90
☐ 4	$840.00	$109.20	$949.20
Optional	**Fee**	**HST**	**Optional Membership Fee**
☐ Practice Manager as Member	$260.00	$33.80	$293.80
		TOTAL FEES:	

*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.

PAYMENT OPTION:

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

16 Digit Card # _____ 4 Digit Expiry _____ 3 Digit CVV _____

Name on Card _____

HST: 107801037RT0001

Please see over...

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.			
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 Address _____

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			

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