Initial Accreditation or Self-Study Application Payment Sheet

**For Calendar Year 2024 Only**

**NOTE: This completed payment sheet MUST be submitted with all forms of payment**

Please Note: Only to be used for an initial accreditation or self-study application sent between **January 1, 2024 and December 31, 2024.**  If not, please contact the Commission Staff for the correct Payment Sheet.

**2024 Initial Accreditation or Self-Study** **Application Fee and Amount Due:**

Advanced and Allied Programs = $16,850; Predoctoral Dental Programs = $67,400

International Predoctoral Dental Programs = $76,660 (Contact CODA for International Payment Sheet)

|  |  |
| --- | --- |
| **Please Remit Payment To:**  **American Dental Association**  **Attn: Accounts Receivable for**  **Commission on Dental Accreditation**  **28094 Network Place**  **Chicago, IL 60673-1280** | **All forms of payment must include the following:**   * **“Remit Payment To” address (exactly as noted to the left)** * **This payment sheet with all information completed, including institution and discipline.** |

|  |
| --- |
| To pay by credit card, please fill out this form and mail to the “Remit Payment To” address below, or  Fax it to 312-440-2567.  Circle One: Visa Mastercard American Express Contact Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Card Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Expiration Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Name on Card: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Signature of Card Holder: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

|  |
| --- |
| Once payment and your Initial Accreditation or Self-Study Application is received, you will receive confirmation from CODA.  Name of Institution: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Contact Name and Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Telephone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ E-mail Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

|  |
| --- |
| Initial Accreditation or Self-Study Application for : (Please Circle One): DPH ENDO OMP OMR  OMS OMS-Fellowship ORTHO ORTHO-Fellowship PEDIATRIC DENTISTRY  PERIO PROS GPR-12 GPR-24 AEGD-12 AEGD-24 DENTAL ANESTHESIOLOGY  ORAL MEDICINE OROFACIAL PAIN DENTAL ASSISTING DENTAL HYGIENE  DENTAL LAB TECH DENTAL THERAPY PREDOCTORAL PREDOCTORAL INTERNATIONAL |

|  |
| --- |
| FOR OFFICE USE ONLY: Please Credit 160-0050-005-43020 |