

Membership Application Form

Name: _____

Address: _____

City *Province* *Postal Code*

Telephone: _____ Fax: _____

Email: _____

Degrees: _____

Medical School at Graduation: _____ Year: _____

- Certification(s): College of Family Physicians of Canada
 Royal College of Physicians and Surgeons of Canada
 Other: _____

Palliative Care Activities

- Full-Time Part-Time 25-50% Palliative Care Trainee
 Part-Time >50% Part-Time <25% None

Major Fields of Medical Activity

- Palliative Care Only Internal medicine Radiation Oncology
 Anesthesia Medical Oncology Geriatrics
 Family Practice Neurology Pediatrics
 General Surgery Obstetrics/Gynecology Other: _____

Language Preference: English French

Dues: \$150.00 (Reduced fee for Palliative Care Trainee of: \$10.00)

Methods of Payment:

Please make cheque payable to: *Canadian Society of Palliative Care Physicians* **OR**

Credit Card: Visa Mastercard Other _____

Card Number

Expiry Date

Card Holder (PRINT)

Authorized Signature

Please send in your application to the Administrative Assistant

*Kathy Robberstad
 Grey Nuns Community Hospital
 416 St. Marguerite HSC
 1090 Youville Drive West
 Edmonton, AB T6L 0A3*

I have read the by-laws of the Canadian Society of Palliative Care Physicians and agree to support its mission and goals.

Signature

Date