2020 APPLICATION FOR MEMBERSHIP

doctors of bc
British Columbia Medical Association

*NOTE: Please complete as many fields as possible, * indicates mandatory fields*
     SAVE and email to: benefits@doctorsofbc.ca
OR SAVE, print and mail to: 115 – 1665 W Broadway, Vancouver BC V6J 4A5

PERSONAL INFORMATION

Surname*	First Name*
2nd Name	3rd Name
Date of Birth* *(mm/dd/yy)*	Gender* M F
SIN*	
College Number*	CMA Number
MSP Billing Number	CMPA Number

BUSINESS ADDRESS   Preferred contact address   *(Please check ONE Address only)*

Clinic/Hospital Name:

Suite #: Street 1:		
Street 2:	City:	Prov:
Postal Code: Country:		
Email Address*:	Phone: Cell:	

HOME ADDRESS   Preferred contact address   *(Please check ONE Address only)*

Suite #: Street 1		
Street 2:	City:	Prov:
Postal Code: Country:		
Email Address*:	Phone: Cell:	

GENERAL INFORMATION

Have you ever been a ***DOCTORS of BC*** member *   Yes   No   If yes:

(mm/dd/yy) Date Joined: Date Terminated: Surname Used:

Residency/Fellowship Institution Name*

Program Name*

     Program Start and End Date* *(mm/dd/yy)* From: To:

As a member of the College of Physicians and Surgeons of British Columbia, I hereby apply for membership in the Doctors of BC, and agree to abide by the By-Laws, Rules and Regulations of the Association.   I will pay online by direct debit or credit card. (*Instructons will be emailed once application is processed.*)

Signature*: _____   **Date***: *(mm/dd/yy)* _____