APPLICATION FOR
Resident 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)*

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)* _____

Doctors of BC respects the privacy of members and is committed to protecting your personal information. Please visit our website at www.doctorsofbc.ca and click on our "Privacy Policy" at the footer of the home page.
Contact and demographic information provided on the Doctors of BC Membership Application will be shared with the CMA only if you choose to join CMA and used in accordance with the CMA's Corporate Privacy Policy. CMA's Corporate Privacy Policy can be found at www.cma.ca, at the footer of the home page.