ASSOCIATE PHYSICIAN MEMBERSHIP APPLICATION

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

PERSONAL INFORMATION

Surname* First Name*

2nd Name 3rd Name

Date of Birth* *(mm/dd/yy)*

CPSID* MSP Billing Number MINC: CAMD-

SIN CMPA Number CMA Number

Corporation Name *(email a copy of your incorporation certificate if not previously provided)*

CONTACT INFORMATION ○ Home ○ Work

Suite # Street 1

Street 2 City Province

Postal Code Country

Email Address* Phone # Cell #*

GENERAL INFORMATION

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

Year Joined (if known) Year Terminated (if known) Surname Used

As a member of the College of Physicians and Surgeons of British Columbia, I hereby apply for membership in 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. *(Instructions 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.

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