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

PERSONAL INFORMATION

Surname* First Name*

2nd Name 3rd Name

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

SIN

CPSID* CMA Number

MSP Billing Number CMPA Number

CONTACT INFORMATION ◉ Home ○ Work

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:

Year Joined (if known) Year Terminated (if known) 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.