APPLICATION FOR STUDENT / IMG CLINICAL TRAINEE 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)* CPSID *:

SIN

HOME ADDRESS

Suite #: Street 1

Street 2: City: Prov:

Postal Code: Country:

Email Address*: Cell*:

GENERAL INFORMATION

Medical Training Institution Name *

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

DOCTORS OF BC MEMBERSHIP DUES*

☐ Student Dues $0.00 ☐ IMG - AIMD BC $0.00

Your free membership covers Doctors of BC membership for all consecutive years enrolled as a medical student/ licensed clinical trainee. You can cancel your Doctors of BC membership at any time by notifying our membership department in writing.

PLEASE NOTE: If your contact information has changed, please update your profile on our website: https://www.doctorsofbc.ca/account/contact

I hereby apply for membership with Doctors of BC and agree to abide by the Bylaws, Rules, and Regulations of the Association.

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.