



CAPIH Membership Application Form

CAPIH Unit #1, 1262 Don Mills Road, Toronto, Ontario M3B 2W7
Phone: 416-443-2568 Toll Free: 1-888-98-CAPIH (22744) Fax: 416-449-2543
E-mail: info@capih.ca www.capih.ca

Name: Family: _____ First: _____ Middle: _____

Male Female

Residence Address:

Street:
City:
Province/State:
Postal Code/Zip:
Telephone:
E-mail:
Spouse Name: Family:

Business Address:

Street:
City:
Province/State:
Postal Code/Zip:
Telephone:
E-mail:
First: _____ Middle: _____

Note: If spouse is a physician/surgeon, separate application must be submitted with the application fee for membership eligibility.

Medical School Attended:

Name:
Year of Graduation:
Province: Country:
Provincial license #

Postgraduate Studies/qualifications:

School: Country:
School: Country:
School: Country:
School: Country:

Current Membership in professional organizations:

Note: Physicians not licensed to practice in Canada must attach a copy of their license from their Medical School of graduation.

Medical Students (please complete the following information)

Medical School you currently attend:
Year of enrolment: Year of graduation:

Clinical Fellows (please complete the following information)

Year of pursuing fellowship: Affiliations:
Hospital(s):

Interested in serving on a CAPIH committee? Yes No Area of interest:

Membership Payment Information:

Note: annual membership fee paid now will provide you with membership privileges for one year from date of payment.

Member:	\$ 100.00	Student Member:	\$ 25.00	Affiliate Member:	\$100.00
Resident Member:	\$ 50.00	Associate Member:	\$ 50.00	Corporate Member:	\$500.00
Non-voting Member:	No Fee	Life Member:	\$ 1,500.00		

Donation: \$ _____ (Your financial support for the association is gratefully appreciated)

To Use Credit Card Turn Form Over

Send Cheque payable to "CAPIH": CAPIH, Unit #1, 1262 Don Mills Road, Toronto, ON, M3B 2W7, Canada

I hereby agree to abide by the constitution and bylaws of this Association:

Signature

CREDIT CARD PAYMENTS

Visa:

Master Card:

Amount:

Account Number:

Expiry:

I agree to pay the above total amount according to the card issuer agreement.

Name (As appears on card) :

Signature:

In order to streamline future membership payments, please authorize payment of annual membership fees of \$100 payable on renewal date of each ensuing year by signing below. This authorization may be cancelled at any time by informing us in writing. Thank you,

Signature:

Date:

Please indicate your preferred mode of receiving CAPIH newsletters and announcements:

Email:

Fax:

Snail Mail:

To pay by credit card please use the attached form. Please make cheques payable to:

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