MEMBERSHIP APPLICATION

Canadian Dermatology Association / Association canadienne de dermatologie

Full Name *(If you prefer to use a nickname, please add)*

Last _____ First _____ Middle _____

Name to appear on correspondence _____

Date of Birth ____ / ____ / ____ (Day / Month / Year) Citizenship _____

Office Address _____

Tel No. _____ Fax No. _____

Email _____

MEDICAL SCHOOL NAME & YEAR OF GRADUATION

_____ Year _____

OTHER UNIVERSITIES & DEGREES OBTAINED

Institution _____ Degree _____ Year _____

Institution _____ Degree _____ Year _____

Institution _____ Degree _____ Year _____

RESIDENCY TRAINING *(List the institution(s) of residency and years training began and completed)*

Institution _____ Position _____ Year _____

Institution _____ Position _____ Year _____

Institution _____ Position _____ Year _____

Institution _____ Position _____ Year _____

FELLOWSHIPS

Institution _____ Year Obtained _____

Institution _____ Year Obtained _____

ADDITIONAL POSTGRADUATE EDUCATION

Institution _____ Position _____ Year _____

TEACHING APPOINTMENTS

Institution _____ Position _____

Institution _____ Position _____

MEMBERSHIP ON HOSPITAL STAFFS

_____ _____

_____ _____

MEMBERSHIP IN MEDICAL SOCIETIES

_____ _____

_____ _____

CERTIFICATION

Fellowship in RCPSC _____ Year _____

CSPQ _____ Year _____

Diplomate of American Board of Dermatology _____ Year _____

Dermatology - Pathology Boards _____ Year _____

Others _____ Year _____

Medical Licensure _____

_____

REFERENCES *(Two CDA members in good standing)*

Name _____ email _____

Name _____ email _____

AREAS OF SPECIAL INTEREST

_____

_____

Are you willing to speak with the media on your areas of specialty? ☐ Yes ☐ No

Preferred language of correspondence with CDA ☐ English ☐ French

Signature _____ **Date** _____

METHOD OF PAYMENT

Amount Due $425.00 + taxes

☐ Cheque payable to **Canadian Dermatology Association** enclosed

☐ Visa ☐ MasterCard ☐ Amex

Account No. _____ **Expiry Date** ____ / ____

Signature _____ **CVC** _____