Application For Change Of Membership Category

The Leaders in Physiatry | Les leaders en physiatrie
CAPM&R
Canadian Association of Physical Medicine & Rehabilitation
Association canadienne de médecine physique et de réadaptation

Please fill in the following form:

General Information

Name: _____ Telephone: _____

Address: _____ Fax: _____

City / Province: _____ Sex: ◯ Male ◯ Female

Postal Code: _____ Date of Birth: (M/D/Y) _____

Email: _____

Provincial Medical Licensure

Province: _____

Year: _____

Type: _____
(if spec. register)

Specialist Qualifications

Qualifications: _____ Year: _____

Granting Body: _____ Speciality: _____

Change Of Category Desired

From: ◯ Medical Student ◯ Resident ◯ Active ◯ Corresponding ◯ Associate

To: ◯ Resident ◯ Active ◯ Corresponding ◯ Retired

Date: _____

Signature of Applicant: _____

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