



L'ASSOCIATION CANADIENNE DES MEDECINS ET CHIRURGIENS BARIATRIQUES

THE CANADIAN ASSOCIATION OF BARIATRIC PHYSICIANS AND SURGEONS

2800 14th Avenue, Suite 210, Markham, ON L3R 0E4 • Tel: (416) 491-2886 • Fax: (416) 491-1670 • E-mail: info@cabps.ca

MEMBERSHIP APPLICATION FORM

Must include signed documentation

I, _____ (First Name) _____ (Initial) _____ (Last Name) hereby apply for membership in the Canadian Association of Bariatric Physicians and Surgeons, and, if approved, agree to abide with the constitution of the said Association.

PRINCIPAL OFFICE/ADDRESS:

Organization/Institute
Number & Street
City
Prov/State Postal/Zip Code
Telephone Fax
E-mail

PROFESSIONAL INFORMATION:

Title:
Hospital Affiliation:
Practice Type:

MEDICAL EDUCATION:

University
City Prov/State/Country
Degrees Year of Graduation:
I am a Member of _____
Provincial/State Licensing Board

I consent to CABPS contacting the necessary authorities, including the Medical Regulatory Authorities and Universities to confirm statements made in this application.

Date: _____ Signature: _____

ACTIVE MEMBERS:

I wish I do not wish

to have my complete contact information as noted above posted on the CABPS website. Members contact information will not be used for any other purpose other than to inform members of CABPS business.

HOME ADDRESS:

Number & Street
City
Prov/State Postal/Zip Code
Telephone Fax
E-mail

ACTIVE MEMBERS:

Check the procedures/treatments you perform:

- Laparoscopic Gastric Bypass
- Laparoscopic Gastric Banding
- Laparoscopic BPD with Duodenal Switch
- Laparoscopic Sleeve Gastrectomy
- Open BPD with/without Duodenal Switch
- Revisional Surgery
- Medical Interventions
- Behavioral Interventions
- Specialized Diets (e.g. VLCD)
- Other _____

(specify)

CANADA ANTI-SPAM REQUIREMENTS:

This section MUST be completed in order for the application to be processed.

CABPS communicates electronically with its membership; in accordance with the Canada Anti-Spam Law, you must indicate whether you wish to receive electronic correspondence from us:

- I AGREE to receive electronic correspondence.
- I DO NOT wish to receive electronic correspondence.



Payment Details

MEMBERSHIP CATEGORIES: [Please select one]	FEE	HST	TOTAL
<input type="checkbox"/> Active [Physicians and Surgeons]	\$250	\$32.50 (13% HST)	\$282.50
<input type="checkbox"/> Associate [Postgraduate Trainee, Retired Physician /Surgeon]	\$80	\$10.40 (13% HST)	\$90.40
<input type="checkbox"/> Affiliate [Allied Health Professionals, Medical Students, Scientists, Surgeons & Surgical Trainees Abroad]	\$60	\$7.80 (13% HST)	\$67.80
<input checked="" type="checkbox"/> IFSO Membership			TOTAL
<input type="checkbox"/> Obesity Surgery (Online version of Journal)	US \$80 OR CDN\$110		\$0.00
<input type="checkbox"/> Obesity Surgery & SOARD (Print and online version of Journal)	US\$150 OR CDN \$206		\$0.00
<input type="checkbox"/> IFSO Membership [non surgeons] (Print and online version of Journal)	US\$20 OR CDN \$27		\$0.00
		SUBTOTAL	\$0.00
		TOTAL	\$0.00

Please note that charges to your credit card will show under the name:

CANADIAN ASSOCIATION OF BARIATRIC PHYSICIANS AND SURGEONS

Cheque enclosed Charge to VISA Mastercard

Card #:

Expiry Date: /

Cardholder's Name: _____
(please print)

Signature: _____

HST #848456968 RT0001

PLEASE TELL US WHO REFERRED YOU TO CABPS:

Name: _____

Profession: _____

Email: _____