L'ASSOCIATION CANADIENNE DES MEDECINS ET CHIRURGIENS BARIATRIQUE

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

Membership Categories: [Please select one]

- ☐ Active $195
- ☐ Associate $95
- ☐ Affiliate $95
- ☐ IFSO Membership
  - ☐ $100 Obesity Surgery
  - ☐ $192 Obesity Surgery & SOARD
  - ☐ $20 IFSO Membership (non surgeons)

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

Cheque enclosed ☐ Charge to ☐ VISA ☐ MasterCard

Please note that charges to your credit card will show under the name:
CANADIAN ASSOCIATION OF BARIATRIC PHYSICIANS AND SURGEONS

Card # Expiry Date /

Cardholder's Name (please print)

Signature