



**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

Obesity Surgery – (US\$80 OR **CDN\$105**)  
 Obesity Surgery & SOARD – (US\$150 OR **CDN \$195**)  
 IFSO Membership [non surgeons] – (US\$20 OR **CDN \$26**)



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.

<p><b>PRINCIPAL OFFICE/ADDRESS:</b></p> <p>Organization/Institute _____</p> <p>Number &amp; Street _____</p> <p>City _____</p> <p>Prov/State _____ Postal/Zip Code _____</p> <p>Telephone _____ Fax _____</p> <p>E-mail _____</p> <p><b>PROFESSIONAL INFORMATION:</b></p> <p>Title: _____</p> <p>Hospital Affiliation: _____</p> <p>Practice Type: _____</p> <p><b>MEDICAL EDUCATION:</b></p> <p>University _____</p> <p>City _____ Prov/State/Country _____</p> <p>Degrees _____ Year of Graduation: _____</p> <p>I am a Member of _____  <i>Provincial/State Licensing Board</i></p> <p>I consent to CABPS contacting the necessary authorities, including the Medical Regulatory Authorities and Universities to confirm statements made in this application.</p> <p>Date: _____ Signature: _____</p> <p><b>ACTIVE MEMBERS:</b></p> <p><input type="checkbox"/> I wish <input type="checkbox"/> 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.</p>	<p><b>HOME ADDRESS:</b></p> <p>Number &amp; Street _____</p> <p>City _____</p> <p>Prov/State _____ Postal/Zip Code _____</p> <p>Telephone _____ Fax _____</p> <p>E-mail _____</p> <p><b>ACTIVE MEMBERS:</b></p> <p><i>Check the procedures/treatments you perform:</i></p> <p><input type="checkbox"/> Laparoscopic Gastric Bypass  <input type="checkbox"/> Laparoscopic Gastric Banding  <input type="checkbox"/> Laparoscopic BPD with Duodenal Switch  <input type="checkbox"/> Laparoscopic Sleeve Gastrectomy  <input type="checkbox"/> Open BPD with/without Duodenal Switch  <input type="checkbox"/> Revisional surgery  <input type="checkbox"/> Medical Interventions  <input type="checkbox"/> Behavioral Interventions  <input type="checkbox"/> Specialized Diets (e.g. VLCD)  <input type="checkbox"/> Other _____ (specify)</p> <div style="border: 1px solid red; padding: 5px;"> <p><b>CANADA ANTI-SPAM REQUIREMENTS:</b></p> <p><b>This section MUST be completed in order for the application to be processed.</b></p> <p>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:</p> <p><input type="checkbox"/> I AGREE to receive electronic correspondence.  <input type="checkbox"/> I DO NOT wish to receive electronic correspondence.</p> </div>
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*Payment Details*

Cheque enclosed  Charge to    

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 \_\_\_\_\_