



L'ASSOCIATION CANADIENNE DES MEDECINS ET CHIRURGIENS BARIATRIQUE
THE CANADIAN ASSOCIATION OF BARIATRIC PHYSICIANS AND SURGEONS

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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.

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| <p>PRINCIPAL OFFICE/ADDRESS:</p> <p>Organization/Institute _____</p> <p>Number & Street _____</p> <p>City _____</p> <p>Prov/State _____ Postal/Zip Code _____</p> <p>Telephone _____ Fax _____</p> <p>E-mail _____</p> <p>PROFESSIONAL INFORMATION:</p> <p>Title: _____</p> <p>Hospital Affiliation: _____</p> <p>Practice Type: _____</p> <p>MEDICAL EDUCATION:</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 the 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>ACTIVE MEMBERS:</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>HOME ADDRESS:</p> <p>Number & Street _____</p> <p>City _____</p> <p>Prov/State _____ Postal/Zip Code _____</p> <p>Telephone _____ Fax _____</p> <p>E-mail _____</p> <p>ACTIVE MEMBERS:</p> <p><i>Check the procedures/treatments you perform:</i></p> <p><input type="checkbox"/> Laparoscopic Gastric Banding</p> <p><input type="checkbox"/> Laparoscopic BPD with Duodenal Switch</p> <p><input type="checkbox"/> Laparoscopic Sleeve Gastrectomy</p> <p><input type="checkbox"/> Open BPD with/without Duodenal Switch</p> <p><input type="checkbox"/> Revisional surgery</p> <p><input type="checkbox"/> Medical Interventions</p> <p><input type="checkbox"/> Behavioral Interventions</p> <p><input type="checkbox"/> Specialized Diets (e.g. VLCD)</p> <p><input type="checkbox"/> Other _____ (specify)</p> |
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Payment Details

Cheque enclosed Charge to   Please note that charges to your credit card will show under the name TAYLOR ENTERPRISES LTD.

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Cardholder's Name (please print) _____

Signature _____