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

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 the 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 Roux-En-Y Gastric Bypass

❑ Laparoscopic Gastric Banding

❑ Laparoscopic BPD with Duodenal Switch

❑ Laparoscopic Sleeve Gastrectomy

❑ Open roux-En-Y Gastric Bypass

❑ Open BPD with/without Duodenal Switch

❑ Revisional surgery

❑ Medical Interventions

❑ Behavioral Interventions

❑ Specialized Diets (e.g. VLCD)

❑ Other _____
(specify)

Payment Details

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

Card # Expiry Date /

Cardholder's Name (please print)

Signature