

Application for Membership (Licensed)

Association of International Medical Doctors of British Columbia (AIMD BC)

www.aimdbc.com

PLEASE PRINT CLEARLY

I. CONTACT INFORMATION

First Name	Nick Name	Initial	Last Name
Address			City
			Postal Code
Email		Confirm Email Address	
		Fax	
Home Phone	Work Phone	Cell Phone	

II. PERSONAL INFORMATION

Age:	Gender:	Year of Arrival in Canada:
Country of Birth:	Nationality:	Languages Spoken:
Degree(s) and Training:		Years (from-to):
Country/countries of Medical Training:	University/ Institute:	# of years as a <i>practicing</i> medical doctor:
Medical Specialization:		# of years as a <i>practicing</i> medical specialist:

VIII. EMPLOYMENT

Current Position Title	Role:
Mailing Address	City/Postal Code

Are you interested in knowing more about becoming a board member? Yes No

Are you interested in knowing more about lecturing, teaching or sponsoring a clinical trainee? Yes No

IX. SIGNATURE (Please sign and date)

I affirm that the information that I have provided is true and correct and that I am a licensed medical doctor in BC.

Signature: _____ Date: _____ Location: _____

ENSURE YOU ALSO FAX A COPY OF YOUR MEDICAL DEGREE AND LICENCE WITH APPLICATION