BRITISH COLUMBIA SURGICAL SOCIETY

APPLICATION FOR MEMBERSHIP

Name: _____

Office Address: _____

_____

City: _____ Postal Code:_____

Tel: (o)_____ (h)_____

Residence Address: _____

City:_____ Postal Code:_____

email:_____

Place and Date of Birth: _____

Medical School or University: _____

Year of Graduation: _____Degree: _____

Post Graduate Training: _____

(State Dates and Sites)

_____

_____

Specialist Degrees Conferred (state year): _____

Specialty: _____Date of Registration in BC_____

Number of years practicing specialty in BC: _____

Dated_____ _____

Signature of Applicant

115 - 1665 West Broadway, Vancouver, B.C. V6J 5A4 Telephone [604] 638-2863 Fax [604] 638-2938