Canadian Cardiac
TRANSPLANT NETWORK

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CANADIAN CARDIAC TRANSPLANT NETWORK MEMBERSHIP APPLICATION FORM

MEMBER INFORMATION

First Name:	Last Name	Initial:
Title:	Gender:	Date of birth: MM/DD/YYYY
Home address:		
City:	Province:	Postal Code:
Home Phone:	Personal Email:	
preferred mailing address : ☐ *home* ☐ *work*		
I am currently a member of the Canadian Cardiovascular Society		

INSTITUTION INFORMATION

Hospital/ Institution:		
Address:		Postal Code:
City:	Province:	Room:
Phone:	E-mail:	Fax:
Job Title:		

EDUCATION INFORMATION

Certification:		
Certified by:		Year:
Degree:	Institution:	Year:
Degree:	Institution:	Year:

MEMBERSHIP TYPE *please choose one*

☐ **Physician / Pharmacist member - $100.00**

☐ **Nurse / Allied Health Professional member - $50.00**

☐ **Member in training**
No fee

Trainee type
Start date: MM/DD/YYYY

Fellowship type:
Expected Completion: MM/DD/YYYY

Each applicant for Trainee membership must be nominated by their program director/supervisor.

PROGRAM DIRECTOR / SUPERVISOR	
Name:	Email address:

Payment Information

☐ **Endorsed cheque** made payable to the Canadian Cardiac Transplant Network

☐ **Credit card:** ☐ MasterCard ☐ Visa EXP:

Credit card #

Name of Cardholder:

PLEASE COMPLETE THIS FORM AND MAIL, SCAN OR FAX TO:

Canadian Cardiac Transplant Network
222 Queen St, Suite 1100
Ottawa, Ontario, K1P 5V9

Email: membership@ccs.ca
Fax: 613-569-6574
Phone: 1-877-569-3407