



Canadian Dermatology Association Association canadienne de dermatologie

Application for Associate Membership

PERSONAL INFORMATION

Full name (If you prefer to use a nickname, please add)

Name to appear on correspondence _____

Date of Birth _____ / _____ / _____ Citizenship _____
Day Month Year

Office address _____

Tel no _____ Fax no _____ Email _____

MEDICAL SCHOOL NAME AND YEAR OF GRADUATION

_____ Year _____

OTHER UNIVERSITIES AND DEGREES OBTAINED

Institution _____ Degree _____ Year _____

Institution _____ Degree _____ Year _____

Institution _____ Degree _____ Year _____

RESIDENCY TRAINING List the institution(s) of residency and years training began and completed

Institution _____ Position _____ Year _____

Institution _____ Position _____ Year _____

Institution _____ Position _____ Year _____

Institution _____ Position _____ Year _____

Institution _____ Position _____ Year _____

FELLOWSHIPS

Institution _____ Year obtained _____

Institution _____ Year obtained _____

ADDITIONAL POSTGRADUATE EDUCATION

Institution _____ Position _____ Years _____

TEACHING APPOINTMENTS

Institution _____ Position _____

Institution _____ Position _____

MEMBERSHIP ON HOSPITAL STAFFS

MEMBERSHIP IN MEDICAL SOCIETIES

CERTIFICATION

Fellowship in RCPSC _____ Year _____

CSPQ _____ Year _____

Diplomate of American Academy of Dermatology _____ Year _____

Dermatology - pathology boards _____ Year _____

Others _____ Year _____

Medical Licensure _____

REFERENCES: Two CDA members in good standing

Name _____ Tel no _____

Name _____ Tel no _____

AREAS OF SPECIAL INTEREST _____

Preferred language of correspondence with CDA English French

