Canadian Society of Ophthalmic Medical Personnel
Société canadienne du personnel médical en ophtalmologie
1565 Carling Avenue, Suite 110, Ottawa, ON, K1Z 8R1

MEMBERSHIP APPLICATION

(Please print clearly)

Last Name: _____ First Name:_____ Middle Initial(s):_____

Address: _____

City: _____ Province: _____ Postal Code: _____

Home Phone: _____ E-Mail: _____

Employers Name: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Business Phone: _____

MEMBERSHIP STATUS (Please circle new or renewing and status)

◯ NEW **or** ◯ RENEWING

Active: $50.00 (2yrs) Student: $25.00 - Program Dir. signature required: _____
(or $35.00 for 1yr)

- Must indicate program & year enrolled in: _____

Joint CSOMP-ATPO: **$75.00US** (1yr)

CERTIFICATE OF ACHIEVEMENT INFORMATION (if available and/or applicable)

Name of Institution: _____ Year Received: _____

JCAHPO Certification: _____ JCAHPO Certification No.: _____

Other Certification: (please include name of institution and year received):

_____

_____

PLEASE PRINT THIS FORM AND MAIL IT IN TO THE ADDRESS BELOW.

Note: Please send a photocopy of your certificate of achievement or JCAHPO certification with this application form. Please specify preferred address for correspondence. Also please note that processing of your application can take up to 6 - 8 weeks. Thank you.

Please make all cheques payable to CSOMP and mail to:

Donna Bong, CSOMP Registrar
Eye Clinic, Royal Alexandra Hospital, 10240 Kingsway Avenue NW
Edmonton, AB, T5H 3V9