



Application for Associate Status (ACBOM)

www.cbom.ca | info@cbom.ca | (888) 223-3808

1. Name: _____
last name first name middle name

2. Mailing Address: _____

3. Telephone: _____ Fax: _____

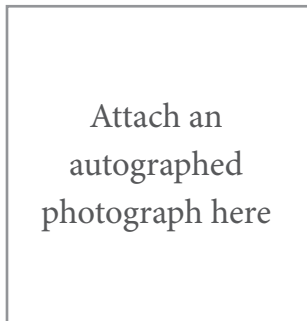
E-Mail Address: _____

4. Foundation Course (Part B): _____
_____ date of completion & location

5. Canadian Medical License Number: _____

6. Licensed by: _____
province/territory

7. Name: _____
The name should be given here in the way you would want it to appear on the certificate.
Include degree(s) if desired.



_____ By initialing in the space next to this clause, I provide my express consent to being contacted, including by email and by other communications, by the Canadian Board of Occupational Medicine and the University of Alberta for purposes related to the Foundation Course and the ACBOM examinations.

Please also include a non-refundable payment of \$350 by filling out the attached form or by cheque made payable to the Canadian Board of Occupational Medicine, 503-386 Broadway, Winnipeg, MB R3C 3R6

Application Deadline: Thursday, March 1, 2018



Credit Card Authorization Form

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Please choose one:

- Visa
 MasterCard

Credit Card Number: _____

Expiration Date: _____ / _____

I, _____, authorize the Canadian Board of Occupational
Medicine to charge the amount of \$_____ to my credit card.

Cardholder Signature

Date

*I/we are aware of any cancellation policies and agree not to dispute or attempt to chargeback
any of the above signed for and acknowledged charges.*

**This page can be returned by fax to 877-947-9767 or
scanned and emailed to info@cbom.ca**