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.

Attach an autographed photograph here

_____ 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

Application Deadline: May 1, 2020

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