

SASKATCHEWAN MEDICAL ASSOCIATION
APPLICATION FOR MEMBERSHIP

Residents complete and return for current mailing information

Last name: _____ First name: _____

Middle name(s) _____

Home address:

Birthdate: ----- Male ---- Female ----

Grad school:

Postal code:

Grad year:

Phone:

Grad country:

Fax:

Email:

Resident Specialty _____ PGY: _____

Expected grad year: _____

I hereby make application for conjoint membership in the Saskatchewan Medical Association and the Canadian Medical Association. I agree to abide by the constitution and bylaws and the code of ethics of the associations.

Date: _____

Signature: _____

- I GIVE permission to have my name and contact information shared within the province of Saskatchewan, for the purposes of recruitment. (ie. RHA's, clinics, saskdocs, municipalities, etc)

Contact and demographic information will be shared with the CMA and used, for example, to contact you by telephone or otherwise with respect to products and services offered through the CMA group of companies. Such information will be used in accordance with the CMA Corporate Privacy Policy available at www.cma.ca.

SMA\Dues_Programs\MEMBERSHIP Letters\Membership miscellaneous\Application forms



SASKATCHEWAN
MEDICAL ASSOCIATION