

CANADIAN HEART FAILURE SOCIETY MEMBERSHIP APPLICATION FORM

MEMBER INFORMATION

| | | | | |
|--|-----------|-----------------|------------------------------|----------|
| First Name: | | Last Name | | Initial: |
| Title: | Gender: | | Date of birth: MM/DD/YYYY | |
| Home address: | | | | |
| City: | Province: | | Postal Code: | |
| Home Phone: | | Personal Email: | | |
| <i>preferred mailing address : home work</i> | | | | |
| I am currently a member of the Canadian Cardiovascular Society | | | | |

INSTITUTION INFORMATION

| | | |
|------------------------|-----------|--------------|
| Hospital/ Institution: | | |
| Address: | | Postal Code: |
| City: | Province: | Room: |
| Phone: | E-mail: | Fax: |
| Job Title: | | |

EDUCATION INFORMATION

| | | |
|----------------|--------------|-------|
| Certification: | | |
| Certified by: | | Year: |
| Degree: | Institution: | Year: |
| Degree: | Institution: | Year: |

MEMBERSHIP TYPE *please choose one*

Regular member \$100.00 (plus applicable taxes) (GST/HST #80351 8794 RT0001)

Each applicant for regular membership must have two nominees that are regular members in good standing. If you do not know two members, contact us at membership@ccs.ca.

NOMINATORS

| | |
|-------|--------|
| Name: | Email: |
| Name: | Email: |

Allied Health Professional member \$25.00 (plus applicable taxes) (GST/HST #80351 8794 RT0001)

Each applicant for AHP membership must be nominated by a CHFS or CCS member in good standing if you do not know a member, contact us at membership@ccs.ca.

NOMINATOR

| | |
|-------|--------|
| Name: | Email: |
|-------|--------|

**Member in training
No fee**

Trainee type
Start date:
MM/DD/YYYY

Fellowship type:
Expected Completion:
MM/DD/YYYY

Each applicant for Trainee membership must be nominated by their program director/supervisor.

PROGRAM DIRECTOR / SUPERVISOR

| | |
|-------|--------|
| Name: | Email: |
|-------|--------|

Payment Information

Endorsed cheque made payable to the Canadian Heart Failure Society

| | | | |
|---------------------|------------|------|------|
| Credit card: | MasterCard | Visa | EXP: |
| Credit card # | | | |
| Name of Cardholder: | | | |

PLEASE COMPLETE THIS FORM AND MAIL, SCAN OR FAX TO:

**Canadian Heart Failure Society
222 Queen St, Suite 1100
Ottawa, Ontario, K1P 5V9**

Email: membership@ccs.ca

Fax: 613-569-6574

Phone: 1-877-569-3407