



The Canadian Critical Care Society
La Societe Canadienne de Soins Intensifs

MEMBERSHIP APPLICATION FORM

Date of Application: _____ / _____ / _____
dd/mm/yy

Surname: _____ Firstname: _____ Initials: _____

Medical School: _____ City: _____ Year of Graduation: _____

Current Position: _____

Attending Staff Resident/Fellows

Base Specialty: _____ Current Position: _____

Hospital: _____

Address: _____

City: _____ Province/State: _____ Postal/Zip: _____

Business Telephone Number: _____ Ext: _____ Fax: _____

Email: _____

Do you wish to be added to the CCCS discussion email list: Yes: No:

Please list two active CCCS members we may contact to support your application:

1. _____ 2. _____

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