

C.S.O.T.

Canadian Society of Orthopaedic Technologists

ASSOCIATE MEMBERSHIP

NAME: Mr. _____
Mrs. _____
Ms. _____ (Surname) _____ (Given Name (s))

ADDRESS: _____
_____ (City) _____ (Province) _____ (Postal Code)

PHONE: _____
(Area Code) _____ (Home) _____ (Business)

DATE OF BIRTH: _____ Email: _____

LIST BELOW YOUR PRESENT APPOINTMENT

ORGANIZATION: _____

ADDRESS: _____
(Street) _____ (City) _____ (Province)

Present Position: _____

Responsible To: _____

Date Employed: From: _____ To: _____

I am applying for Associate Membership. I realize that I will not be entitled to take part in the voting process, hold elected office in the Society nor sit the Registry Examinations.

I will commit no act which will bring discredit to the Society.

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Signature of Applicant _____ Date _____

Make Cheque or Money Order Payable to: C.S.O.T.
Mail to: 18 Wynford Drive, Suite715A
North York ON M3C 3S2
Phone:(416) 445-4516 Fax (416) 489-7356
Email csot@look.ca
Web www.pappin.com/csot

MEMBERSHIP FEE: \$90.00 PER YEAR + \$21.40 APPLICATION FEE