

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.

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: \$102.00 PER YEAR + \$25.00 APPLICATION FEE HST Included.