

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. I have never been convicted of a criminal offense.

Signature of Applicant Date

Make Cheque or Money Order Payable to: C.S.O.T.
Mail to: 18 Wynford Drive, Suite 715A
North York ON M3C 3S2
Phone: (416) 445-4516 Fax (416) 489-7356
Email csot@look.ca
Web www.pappin.com/csot

MEMBERSHIP FEE: \$130.00 PER YEAR + \$25.00 APPLICATION FEE HST Included.