**QBMA Membership Registration**

**Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last First

**Email:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Profession:**

|  |  |  |
| --- | --- | --- |
| Health Care Professional | Health Care Student | Pre-Health Care Student |
| Physician  Nurse  Physiotherapist  Pharmacist  Dietician  Dentist  Kinesiotherapy  Occupational therapist  Other \_\_\_\_\_\_\_\_\_\_\_\_ | Medicine  Nursing  Physiotherapy  Pharmacy  Dietetics  Dentistry  Kinesiology  Occupational therapy  Other \_\_\_\_\_\_\_\_\_\_ | CEGEP  High School  Other \_\_\_\_\_\_\_\_\_\_\_\_ |

|  |  |
| --- | --- |
| **Professional Office Address:** | **Mailing Address:** |

**Telephone Numbers:**

\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Work Home Cell

**Area of Interest:**

Mentorship program (mentor or mentee)

Events Planning

Guest Speaker

Research Project Supervision

Medical Observership

Other

|  |  |
| --- | --- |
| **Date:** | **Signature:** |

Note: Please email completed form to: qbma.president@gmail.com