**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