CANADIAN ORGANIZATION OF MEDICAL PHYSICISTS

ORGANISATION CANADIENNE DES PHYSICIENS MÉDICAUX

P.O. Box 72024 Kanata North RPO
Kanata, ON K2K 2P4
Ph: (613)599-1948 Fax: (613)599-1949 Email: admin@medphys.ca

Application for Membership

Name: _____ (Dr (Male/Female) / Mr / Ms / Mrs [*please circle*]

Mailing Address: _____ (Home) or (Institute)

_____ Tel: ( )_____

_____ Fax: ( )_____

_____ Email: _____

Postal/Zip Code: _____ Website: _____

Present Position: _____

Highest Degree: _____ ***Year Graduated:*** _____ ***Area of Specialty***:

Please ✓one = ☐ **Therapeutic Radiological Physics** ☐ **Diagnostic Radiological Physics** ☐ **Nuclear Medicine Physics** ☐ **Magnetic Resonance Imaging** ☐ **Health Physics / Radiation Safety** ☐ **Other**

Other Memberships: CCPM ☐ AAPM ☐ HPA ☐ CAP ☐ SPIE ☐ SPSE ☐ CRPA ☐ *other* ☐

I wish to join COMP as a…

Full Member*		**Associate Member***		**Student Member**		**Retired Member**	
($100)	☐	($100)	☐	($20)	☐	($20)	☐

***PLUS* $30.00** processing fee ☐ *(Full and Associate members)*

Subscription to: *"Physics in Medicine and Biology"* ---- $400.00 Cdn --------- ☐

"Physics in Canada" ----------$40.00 Cdn --------- ☐

I enclose my cheque for $_____, payable to COMP.

Signature: _____ ***Date:*** _____

Verification of Eligibility

To be completed by employer or University/Hospital Department Chairperson

This is to verify that _____ is currently:

☐ Actively employed as a medical (hospital, health, bio-) physicist

☐ Enrolled in a graduate program in medical physics. He/she is registered as a full-time university student studying towards a degree.

Institution, Department, etc. _____

_____ _____

(name and position) *(date and signature)*