



CANADIAN ASSOCIATION OF NIGERIAN PHYSICIANS AND DENTISTS
(CANPAD)

MEMBERSHIP REGISTRATION FORM
2012

Name: _____

Sex: Male Female

Spouse Name: _____

Mailing Address: _____

Work Phone: (_____) _____ Home Phone: (_____) _____

Fax # (_____) _____ E-Mail Address: _____

Specialty: _____

Medical School Attended: _____

Year of Graduation: _____

Post Graduate Training At: _____

What suggestion(s) do you have regarding the goals and aspirations of CANPAD?

What aspect of CANPAD activities are you particularly interested in?

Annual membership dues: \$ 300.00 for Physicians & Dentists in Full-time Practice or
\$ 50.00 for Fellows, Residents, Interns, and Physicians not yet in full practice.

Voluntary contribution to CANPAD Bursary Fund \$ _____

Payment Deadline: January 31, 2012

You may make payment by Credit Card on the CANPAD web site through **Paypal**
or send Visa or Mastercard # _____ Exp Date ____/____ by

Fax to 705-728-0980 or Tel. 705-728-1697 or

Make cheque payable to: CANPAD and mail to - Dr. Modupe Tunde-Byass

The Treasurer, CANPAD
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