



CANADIAN ASSOCIATION OF NIGERIAN PHYSICIANS AND DENTISTS
(CANPAD)

MEMBERSHIP REGISTRATION FORM
2010

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Sex: Male Female

Spouse's Name: _____

Mailing Address: _____

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

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

Specialty: _____

Medical School Attended: _____

Year of Graduation: _____

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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.
\$ 50.00 for Fellows, Residents, Interns, and Physicians not yet in Full-time Practice.

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