



## Application for Full Membership

### PERSONAL INFORMATION:

Title:  Dr.

Name in Full: First: \_\_\_\_\_ Last: \_\_\_\_\_

Date of Birth: (dd/mm/yyyy) \_\_\_\_\_ Male:  Female:

Work Address: \_\_\_\_\_  
\_\_\_\_\_

Work Telephone No: \_\_\_\_\_ Work Fax No.: \_\_\_\_\_

Home Address: \_\_\_\_\_  
\_\_\_\_\_

Home Telephone No: \_\_\_\_\_ Home Fax No.: \_\_\_\_\_

Email Address: \_\_\_\_\_

Please mail members package to my: HOME  WORK

Newsletters and up-dates will be sent out by email. Hard copies will be mailed upon request only.  
Please notify us **if** you are unable to receive correspondence by email.

# LICENSING / CERTIFICATION

## Full Membership (Physicians):

Date and Place Medical Degree was obtained:

University: \_\_\_\_\_

Province / Country: \_\_\_\_\_

Date: (MM/DD/YEAR): \_\_\_\_\_

Current Licenses Held (please include your License #): \_\_\_\_\_

\_\_\_\_\_

Specialist Qualifications (if applicable): \_\_\_\_\_

Are you currently a member in good standing of your licensing body?      Yes          No   

Are there currently any complaints lodged against you?      Yes          No   

Names and addresses of two professional references who can substantiate your information supplied:

### Reference One:

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

Address: \_\_\_\_\_

\_\_\_\_\_

Telephone No.: \_\_\_\_\_ Email: \_\_\_\_\_

### Reference Two:

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

Address: \_\_\_\_\_

\_\_\_\_\_

Telephone No.: \_\_\_\_\_ Email: \_\_\_\_\_

## **PAYMENT OPTIONS:**

Please make cheque or money order payable to the Canadian ADHD Resource Alliance (or CADDRA), or provide credit card information below.

**Full Membership:** Fees: \$200.00 + \$26.00 HST = \$226.00

MasterCard

Visa

Cheque Enclosed

Card Number: \_\_\_\_\_ Expiry Date: \_\_\_\_\_

Name of Cardholder (as it appears on card): \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### **Declaration:**

**I understand that CADDRA will make inquiries about my professional training and practices, either from professional societies, individual references or any other individuals who may know my past or present professional activities, if such are deemed necessary. I also understand that CADDRA is not obligated to offer membership on the basis of this application.**

**I affirm that all the information in this application is true.**

Date: \_\_\_\_\_ Signature: \_\_\_\_\_

### **Return to:**

Canadian ADHD Resource Alliance (CADDRA)  
Membership Department  
3950 14<sup>th</sup> Avenue  
Markham, ON L3R 0Y9  
or fax: 905-475-3232