



Application for Membership

Resident

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.

LICENSING / CERTIFICATION

Resident Membership:

Residents:

If enrolled in postgraduate course, please specify:

University: _____

Description of Program: _____

Expected completion date of the program (MM/DD/YYYY): _____

ENDORSEMENT FOR RESIDENTS

Name of University or College: _____

Description of Program: _____ Year _____ of a _____ year program.

Expected Completion Date of Program (MM/DD/YYYY): _____

I the undersigned, certify that the applicant is engaged in health profession training, or postgraduate training at the above mentioned university or college.

Name: Dean of Program, Department Head, or Program Registrar (PLEASE PRINT)

Signature

Date

PAYMENT OPTIONS:

Please make cheque or money order payable to the Canadian ADHD Resource Alliance (or CADDRA), or provide credit card information below. **Resident Membership Fees: \$50.00 + \$ 6.50 HST = \$56.50**

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 14th Avenue, Suite 604

Markham, ON L3R 0A9

tel: 416-637-8583

fax: 905-475-3232

***Please remember to submit copies of all documentation required.**