

Membership Application Form

Welcome to the Sunshine Coast Division of Family Practice! Membership is open to all family physicians on the Sunshine Coast, including Locums, as well as specialists and recent retirees. All information on this form will be kept confidential.

The Sunshine Coast Division of Family Practice gives local physicians an opportunity to address common health care goals, including:

- improving local primary care
- having a greater influence on health care delivery and policy; and
- providing professional support for physicians.

We look forward to you joining us!

Contact Information

Name:	
Mailing Address:	
Email Address:	
Cell Number:	
Telephone Number:	
MSP Number:	
SIN Number: (for T4 and T4A purposes)	
Are you incorporated? If so, please provide the following: Full corporate name of your company, and Revenue Canada business number (i.e., 12345 6789 RP0001)	

Getting to Know Our Members

Please describe your practice. (Please check all that apply)			
<input type="checkbox"/>	GP admitting privileges	<input type="checkbox"/>	GP with no admitting privileges
<input type="checkbox"/>	Locum	<input type="checkbox"/>	Recently Retired/Semi-retired
<input type="checkbox"/>	Specialist	<input type="checkbox"/>	Resident
<input type="checkbox"/>	Other:		

Ways that I might be interested in being involved. (Please check all that apply)	
<input type="checkbox"/>	social networking opportunities
<input type="checkbox"/>	engaging in issue discussion & solution finding (e.g. focus groups, discussion panels, etc.)
<input type="checkbox"/>	being part of a working/planning group or taking a role in developing a future initiative
<input type="checkbox"/>	receiving information/updates re. division and board activities
<input type="checkbox"/>	serving as board member
<input type="checkbox"/>	specific clinical area(s) of interest:

Areas of challenge (Please check all that apply)	
<input type="checkbox"/>	finding a locum
<input type="checkbox"/>	concerns about impending retirement
<input type="checkbox"/>	communication with?
<input type="checkbox"/>	Other

Are you a member of any other Division of Family Practice in British Columbia?
 _____ yes _____ no

If yes, please provide Division name: _____

Additional Information: _____

Participation and Compensation

As a member of the Division, you may from time to time be asked to share your thoughts and opinions on an area of interest. This may be solicited in a number of ways, such as a casual discussion, as part of a working group or via e-mail. Your participation is completely voluntary. However, if you do choose to assist the Division, we want to acknowledge the value of your time and contribution with an honorarium based on the current sessional rate, as set out by the Doctors of BC.

By providing your banking information (either corporate or personal account), the Division will make arrangements for your sessional payments to be made directly to your bank account through electronic funds transfer (EFT).

_____ Yes, I have attached a voided cheque.

Agreement and Signature

Printed Name

Signature

Date

I agree that information gained as a member of the Sunshine Coast Division of Family Practice, "The Division", will remain confidential. I will not share or reveal any personal information I learn as a member of this organization.

I acknowledge and agree that the information in this Membership Registration form is collected to confirm membership in the Division and may be used for the purposes of communicating any information from the Division that is deemed necessary. The information collected will remain the confidential property of the Division and will not be shared with any third parties, with the exception of the BCMA/GPSC, which may need membership information in order to assess and allocate the appropriate funding to the Division.

PLEASE RETURN YOUR COMPLETED FORM TO:

Sonja Sorensen, Administrative Assistant

eMail: ssorensen@divisionsbc.ca

OR mail your application to:

Sunshine Coast Division of Family Practice
 Box 274, Sechelt, B.C. V0N 3A0