Chilliwack
Division of Family Practice
A GPSC initiative

Membership Registration

Name: _____ MSP Billing #_____
(Your billing number is needed to process any Compensation from the Division)

E-Mail: _____

Office Address: _____

City:_____ Postal Code: _____

Office Phone: _____ Fax: _____

Cell Phone: _____

Please indicate your preferred method of contact: ___ Phone ___ Email ___ Fax

The following questions are designed to check your interest level in various aspects of the Division. Checking an item in no way commits you to do that item. 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 telephone conversation, a casual discussion, as part of a working group, 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/hourly rate set by the Doctors of BC.

I am interested in:

____ serving as board member
____ being part of a working/planning group.
____ taking a lead role in the development of a future program
____ continuing hospital patient care
____ Other _____

Information gained as a member of the Chilliwack 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 Doctors of BC/GPSC which may need membership information in order to assess and allocate the appropriate funding to the Division.

_____ _____
Signature Date