

SIDFP Membership Enrollment

*** Required fields**

GENERAL INFORMATION:

Salutation:						
First Name:*						
Last Name:*						
Suffix:						
Member Type:*	<input type="checkbox"/> Committee Partner <input type="checkbox"/> Guest – BCMA <input type="checkbox"/> Guest – Community <input type="checkbox"/> Guest – GPSC <input type="checkbox"/> Guest – Health Authority <input type="checkbox"/> Guest – MOH <input type="checkbox"/> Guest – Other	<input type="checkbox"/> Guest – Supplier <input type="checkbox"/> Midwife <input type="checkbox"/> Nurse – Practitioner <input type="checkbox"/> Nurse – Registered <input type="checkbox"/> Physician <input type="checkbox"/> Physician – ERP <input type="checkbox"/> Physician – Hospitalist	<input type="checkbox"/> Physician – Lead <input type="checkbox"/> Physician – Locum <input type="checkbox"/> Physician – Non-Member <input type="checkbox"/> Physician – Resident <input type="checkbox"/> Physician - Retired			
Practice Community:*	<input type="checkbox"/> Brentwood Bay <input type="checkbox"/> Central Saanich <input type="checkbox"/> Colwood <input type="checkbox"/> Esquimalt <input type="checkbox"/> Langford <input type="checkbox"/> Metchosin	<input type="checkbox"/> North Saanich <input type="checkbox"/> Oak Bay <input type="checkbox"/> Saanich <input type="checkbox"/> Saanichton <input type="checkbox"/> Sidney <input type="checkbox"/> Sooke	<input type="checkbox"/> South Island - Committee Partner <input type="checkbox"/> Vic West <input type="checkbox"/> Victoria (South Island) <input type="checkbox"/> View Royal			
MSP Billing Number:			CFPC Number:			
Payable To:						

CONTACT INFORMATION:

Preferred Email to be Listed in Division Contact Directory: *		<input type="checkbox"/> Work	<input type="checkbox"/> Home	<input type="checkbox"/> Division	
Email:*	Work:				
	Home:				
	Division:				
Phone:*	Preferred Phone:	<input type="checkbox"/> Work	<input type="checkbox"/> Home	<input type="checkbox"/> Division	
	Work:				
	Home:				
	Cell:				
Fax Number:			Pager Number:		

Preferred address to be used for mailing purposes:*		<input type="checkbox"/> Work	<input type="checkbox"/> Home
Clinic / Office Name:			
Practice Type:*	<input type="checkbox"/> Emergency	<input type="checkbox"/> Office – no hospital privilege	
	<input type="checkbox"/> Hospital	<input type="checkbox"/> Office – with hospital privilege	
	<input type="checkbox"/> Hospitalist	<input type="checkbox"/> Other: _____	
	<input type="checkbox"/> Obstetric Clinic Only	<input type="checkbox"/> Specialist: _____	
	<input type="checkbox"/> Office	<input type="checkbox"/> Walk-in Clinic	
Web Address:			
Work Address:	Address 1:		
	Address 2:		
	City:	Province:	Postal Code:
Home Address:	Address 1:		
	Address 2:		
	City:	Province:	Postal Code:

Do you have Committee or Board experience?

No Yes Explain: _____

How long have you been working as a physician in the Victoria area?

_____ years

Are there areas of interest or special training of your practice?

In order to better understand our members, please identify any special interests you are currently involved in or would like to be involved in.

In order to better understand the issues affecting our members, please identify your main challenges with primary care in our region, or any projects or programs you are aware of that could support local primary care.

Please forward completed Membership Form to:

#201 - 4480 West Saanich Rd., Victoria, BC V8Z 3E9
 Phone: 250.658.3303 | Fax: 250.658.3304 | E-mail: info@sidfp.com

