South Island
Division of Family Practice
A GPSC initiative

#203 - 4489 Viewmont Avenue, Victoria, BC V8Z 5K8
Phone: 250.658.3303 | Fax: 250.658.3304 | E-mail: info@sidfp.com

SIDFP Membership Enrollment

*** Required fields**

GENERAL INFORMATION:			
Salutation:			
First Name:*			
Last Name:*			
Suffix:			
Member Type:*	☐ Committee Partner ☐ Guest – BCMA ☐ Guest – Community ☐ Guest – GPSC ☐ Guest – Health Authority ☐ Guest – MOH ☐ Guest – Other	☐ Guest – Supplier ☐ Midwife ☐ Nurse – Practitioner ☐ Nurse – Registered ☐ Physician ☐ Physician – ERP ☐ Physician – Hospitalist	☐ Physician – Lead ☐ Physician – Locum ☐ Physician – Non-Member ☐ Physician – Resident ☐ Physician - Retired
Practice Community:*	☐ Brentwood Bay ☐ Central Saanich ☐ Colwood ☐ Esquimalt ☐ Langford ☐ Metchosin	☐ North Saanich ☐ Oak Bay ☐ Saanich ☐ Saanichton ☐ Sidney ☐ Sooke	☐ South Island - Committee Partner ☐ Vic West ☐ Victoria (South Island) ☐ View Royal
MSP Billing Number:		**CFPC Number:**	
Payable To:			
Are you a member of any other Division?	☐ Yes ☐ No	**If yes, which one?**	

CONTACT INFORMATION:		
Email:*	**Preferred Email:**	
	Work Email:	
	Home Email:	
	Division Email:	
Preferred Email to be Listed in Division Contact Directory: *	☐ Work Email ☐ Home ☐ Division	
Phone:*	**Preferred Phone:**	☐ Work Email ☐ Home ☐ Division
	Work Phone Number:	
	Home Phone Number:	

	Cell Phone Number:				
Fax Number:		**Pager Number:**			
Preferred address to be used for mailing purposes:*		☐ Work	☐ Home		
Clinic / Office Name:					
Practice Type:*	☐ Emergency ☐ Hospital ☐ Hospitalist ☐ Obstetric Clinic Only ☐ Office	☐ Office – no hospital privilege ☐ Office – with hospital privilege ☐ Other: _____ ☐ Specialist: _____ ☐ 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:**

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.

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

FOR OFFICE USE ONLY			
Date Received:		**Received By:**	
Submitted to Board:		**Approved by Board:**	
Package Sent to Member:		**Notes:**	

Please forward completed Membership Form to:

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