



Clinic Membership Application Form

- **Clinic Member:** Any independent health care facility providing medical services or medical support services
- **Annual Membership Fee:** clinics with less than 10 physicians - **\$450**; clinics with 10 or more physicians - **\$850**

Clinic/Facility Contact Information:

Clinic/Facility Name: _____

Address: _____
City: _____
Province: _____ Postal Code: _____
Phone: _____ Fax: _____
Email: _____
Website: _____

Individuals to contact in your facility:

Main Contact

Name/Title: _____
Phone: _____
Email: _____

President/CEO

Name/Title: _____
Phone: _____
Email: _____

Medical Director

Name: _____
Phone: _____
Email: _____

Director of Nursing or Administrator

Name/Title: _____
Phone: _____
Email: _____

Clinic/Facility Information:

Facility Type: _____
General: _____
Specialist: (list specialties): _____

Diagnostic Imaging: CT MRI PET Other Imaging
Specify "Other Imaging": _____
Other Facility Type: _____

Total # of MDs: _____ *Total # of other staff:* _____

Payment Information:

Membership Fee: (\$) _____
Donation (Optional): (\$) _____
Total Enclosed: (\$) _____
Checks: **Please make cheques payable to CIMCA**
Credit Cards: **Visa or MasterCard or AMEX**
Credit Card #: _____
Expiry Date: _____
Cardholder's Name: _____
Cardholder's Signature: _____

Sign-up Date: _____

Please return completed application with payment to:
Canadian Independent Medical Clinics Association
245 - 280 Nelson Street
Vancouver, BC, V6B 2E2
Or, if using a credit card, fax to: (604) 648-9379
For more information call: (604) 688-6364