BC BALANCE & DIZZINESS DISORDERS SOCIETY

Professional Membership Application

(Please print clearly)

Date: _____ Title (optional): _____ (Ms., Mr., Dr., etc.)

Name: _____

Post nominal letters (e.g., BSc PT): _____

Please note: Information provided in this shaded box will NOT appear in the directory

Home street address: _____

City: _____ Province: _____ Postal code: _____

Phone: (_____)_____ Email: _____

I would like to receive the newsletter by:

Email only _____ Postal mail only _____ Both email and postal mail _____

What evidence-based continuing education in diagnosing and/or treating vestibular disorders have you completed? Please be specific - provide names of courses/certificates as well as completion dates.

_____

_____

_____

_____

Brief biography: *(up to 100 words)* _____

_____

_____

_____

_____

_____

Clinic/practice information *- list up to four locations where you work*

Clinic/practice name 1: _____

Street address: _____

City: _____ Postal Code: _____

Phone: _____

Website: _____

Email: _____

Languages Spoken: _____

Clinic/practice name 2: _____

Street address: _____

City: _____ Postal Code: _____

Phone: _____

Website: _____

Email: _____

Languages Spoken: _____

Clinic/practice name 3: _____

Street address: _____

City: _____ Postal Code: _____

Phone: _____

Website: _____

Email: _____

Languages Spoken: _____

Clinic/practice name 4: _____

Street address: _____

City: _____ Postal Code: _____

Phone: _____

Website: _____

Email: _____

Languages Spoken: _____

Enclosed: _____ Membership fee ($50/year)
_____ Donations appreciated – we are entirely funded by donations & memberships
_____ **Total**

Please make cheques out to "Treasurer BC Balance and Dizziness Disorders Society" and mail to:
BC Balance and Dizziness Disorders Society, Box 325 – 5535 West Boulevard, Vancouver BC V6M 3W6