



Canadian Society of Ophthalmic Medical Personnel
Soci t  canadienne du personnel m dical en ophtalmologie
c/o COS, 1525 Carling Avenue, Suite 610, Ottawa, ON, K1Z 8R9

MEMBERSHIP APPLICATION (2 Years)

Last Name: _____ First Name: _____ Middle Initial(s): _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Home Phone: _____ E-Mail: _____

Employers Name: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Business Phone: _____

MEMBERSHIP STATUS (Please circle status and new or renewing)

Active: \$50.00 Student: \$25.00 - Program director signature required: _____

(\$35.00 for 1 year)

New Renewing - Must indicate program & year enrolled in: _____

CERTIFICATE OF ACHIEVEMENT INFORMATION (if available and/or applicable)

Name of Institution: _____ Year Received: _____

JCAHPO Certification: _____ JCAHPO Certification No.: _____

Other Certification: (please include name of institution and year received):

PLEASE PRINT THIS FORM AND MAIL IT IN TO THE ADDRESS BELOW.

* Note: Please send a photocopy of your certificate of achievement or JCAHPO certification with this application form.

Please specify preferred address for correspondence. Thank you.

Please make all cheques payable to CSOMP and mail to:

**CSOMP Registrar
9841 – 76th Street
Edmonton, AB, T6A 3A1**