



**CASEM MEMBERSHIP RENEWAL FORM  
FROM JANUARY 1, 2021 TO DECEMBER 31, 2021**

**Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**City:** \_\_\_\_\_ **Province:** \_\_\_\_\_ **Postal Code:** \_\_\_\_\_

**Office Phone:** \_\_\_\_\_ **Ext** \_\_\_\_\_

**E-mail:** \_\_\_\_\_ **Cell** \_\_\_\_\_

**Language:** English (  ) French (  )

**Public Directory Information:** (If you wish your clinic listed on the public directory, complete this section)

**Clinic Name:** \_\_\_\_\_

**Clinic Address:** \_\_\_\_\_

**Clinic City:** \_\_\_\_\_ **Province:** \_\_\_\_\_ **Postal Code:** \_\_\_\_\_

**Office Phone:** \_\_\_\_\_ **Ext** \_\_\_\_\_

**E-mail:** \_\_\_\_\_ **Clinic Website:** \_\_\_\_\_

**Specialty:** \_\_\_\_\_

**(A) MEMBERSHIP DUES TOTAL**

- |  |           |
|--|-----------|
| <input type="checkbox"/> Active Member                                   | \$ 350.00 |
| <input type="checkbox"/> Post graduate medical trainee (Resident/Fellow) | \$ 175.00 |
| <input type="checkbox"/> Senior Member (retired)                         | \$ 175.00 |
| <input type="checkbox"/> Student Member*                                 | \$ 25.00  |

\*Clinical Journal of Sport Medicine NOT included

**(B) OPTIONAL DONATION** (tax deductible)

Please choose donation type: (  ) Research Fund (  ) L. Richard Fund (  ) General

**Total Donation:** (B) \$ \_\_\_\_\_

**TOTAL AMOUNT ENCLOSED**

**ADD LINE A+B FOR TOTAL AMOUNT PAYABLE** \$ \_\_\_\_\_ (CDN)



**METHOD OF PAYMENT** (\*CVC is the 3 digits on the back of your card)

- VISA CARD NUMBER: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ EXP DATE: / / \*CVC: \_\_\_\_\_
- M/C CARD NUMBER: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ EXP DATE: / / \*CVC: \_\_\_\_\_
- CHEQUE NUMBER: \_\_\_\_\_

**DISTRIBUTION OF CASEM MEMBERSHIP DATABASE**

Check here if you **DO NOT APPROVE** distribution of your contact information (home numbers are NEVER published). Contact information can be distributed to National Sport Federations, CASEM Website Members' Only Section, other related organizations, sponsors, etc.

**MEMBERSHIP VERIFICATION**

I certify that I am a physician licensed to practice in the province of \_\_\_\_\_ registration number \_\_\_\_\_. I started practicing medicine in the year (please state year) \_\_\_\_\_

**OR**

I am a postgraduate medical trainee or medical student. **Please supply a copy of your medical school registration.**

**OR**

I am a senior (retired from active medical practice) in the province of \_\_\_\_\_. Life Members and Honourary Members are appointed. I \_\_\_\_\_ confirm that the information completed on this application is true to the best of my knowledge. (Membership becomes invalid immediately for false information provided on this form without refund or compensation of lost membership dues).

Signature \_\_\_\_\_ Date: \_\_\_\_\_

**NEW ADDRESS:**

Please note that CASEM Head Office has moved.  
If you are mailing in your renewal please use the address below:

CASEM - House of Sport  
2451 Riverside Drive  
Ottawa ON K1H 7X7