## Image

**Application for Membership in the CCPM**

**(All Information must be printed or typed)**

**Section 1. General Information**

Title: Mr.[ ]  Ms. [ ]  Mrs. . [ ]  Dr: . [ ]

**(Enter name as you would want it to appear on your certificate)**

First Name:  Middle or Initial:  Last Name: 

Address:

Street:  City, Prov/State:  Postal Code: 

Country:  Phone:  Email: 

**References:**

Note: Re: US NRC Authorized Medical Physicist Status:

The U.S. NRC accepts MCCPM as part of a shortened application for Authorized Medical Physicist status, if the Radiation Oncology Physics MCCPM candidate must was supervised by a MCCPM or ABR certified medical physicist for a period of at least 2 years by March 31st of the exam year.

Radiation Oncology Sub-Specialty: Indicate whether you have been supervised for a minimum of 2 years by a MCCPM or ABR-certified person as described above:

No [ ]  Yes [ ]  (if Yes, Supervisor’s Name): 

Medical Physicist Name:  Certification:  Phone: 

Institution: 

Address:

Street:  City, Prov/State:  Postal Code: 

Country:  Relationship to Applicant: 

Medical Physicist Name:  Certification:  Phone: 

Institution: 

Address:

Street:  City, Prov/State:  Postal Code: 

Country:  Relationship to Applicant: 

Physician’s Name:  Certification:  Phone: 

Institution: 

Address:

Street:  City, Prov/State:  Postal Code: 

Country:  Relationship to Applicant: 

**Section 2. Provide the information requested below on this sheet or a separate sheet or, for Sections 2.1 to 2.3, indicate that the information is clearly stated in your attached CV:**

2.1 Education [Minimum M.Sc. from an accredited university in relevant field – Bylaws Article 2.02 (a)]:

Highest Degree Granted: M.Sc. Ph.D. Other: 

|  |  |  |
| --- | --- | --- |
| INSTITUTION  | MAJOR  | YEAR  |

Other Education: see CV

|  |  |  |  |
| --- | --- | --- | --- |
| INSTITUTION  | MAJOR  | DATES ATTENDED  | DEGREE  |

2.2 Professional Societies (including other certifications): see CV

|  |  |  |  |
| --- | --- | --- | --- |
| SOCIETY  | DATES  | MEMBERSHIP GRADE  | OFFICES HELD  |

2.3 University, Cancer Clinic and Hospital Appointments: see CV

|  |  |  |  |
| --- | --- | --- | --- |
| INSTITUTION  | DEPARTMENT  | APPOINTMENT  | DATES  |

2.4 Professional Experience: see CV

|  |  |  |  |
| --- | --- | --- | --- |
| EMPLOYER  | TITLE OR POSITION  | DUTIES | DATES  |

**Section 3. Application for Membership**

Fill out parts A, B, C and D.

**A. Required Patient-Related Experience: (Regulations section D.2.2)**

**I am applying to take the 20** **membership exam and submit that as of**  **(Date)**

**I will have**  **years of patient-related experience as defined in the CCPM Regulations.**

Claim one year for each year of full time equivalent on-the-job patient-related experience in medical physics. (**Do not** count any of the time in a university degree program):

**(A minimum of two years is required)**

**B. Select Sub-Specialty:**

[ ]  Radiation Oncology Physics:

[ ]  Nuclear Medicine Physics:

[ ]  Diagnostic Radiological Physics:

[ ]  Magnetic Resonance Imaging:

[ ]  Je demande que l’examen écrit se déroule en français

[ ]  Je demande que l’examen oral se déroule en français

**C. Canadian Connection Requirement: (Regulations section D.2.8)**

The membership certification process is intended to serve Canadians. Candidates are expected to fulfill at least one of the following. Please check one:

[ ]  Canadian Citizen [ ]  Resident of Canada [ ]  Completed a university degree in Canada

[ ]  Completed a medical physics residency program in Canada [ ]  Confirmed job offer in Canada

**D. Non Disclosure Agreement (Regulations section C.8.1)**

[ ]  I have read the CCPM Regulations, in particular Sections C.8.1 and D.3.3, and by signing this application, I acknowledge I am aware of the CCPM statement of Non disclosure and Cheating and agree to abide by it.

[ ]  I certify that the information contained in this application and in the accompanying curriculum vitae is true.

I agree to accept the Board of the Canadian College of Physicists in Medicine as the sole judge of my qualifications in order to be and to remain a Member of the College. I authorize the CCPM to contact individuals and/or institutions for any confirmation that is needed.

Signed\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date 

Completed forms with the application fee should be sent to:

**CCPM Registrar**

**300 March, Suite 202**

**Kanata ON K2K 2E2
Gisele.kite@ccpm.ca**

**If paying by credit card, please complete the following:**

Visa/MasterCard #: Exp.Date / CVV: : 

Card Holder’s Name: 

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