



## Professional Membership Application

(Please print clearly)

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

Name: \_\_\_\_\_ Title (optional): \_\_\_\_\_

Post nominal letters: \_\_\_\_\_

**Please note: The information provided in this shaded box is for office use only and will NOT appear in the directory. We will use it to communicate with you about your professional membership.**

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 \_\_\_\_\_

Relevant certification/dates: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Brief biography: *(up to 100 words)* \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Languages spoken (in addition to English): \_\_\_\_\_

## Clinic/practice information:

*(list up to three locations where you work)*

Clinic/practice name: \_\_\_\_\_

Street address: \_\_\_\_\_

City: \_\_\_\_\_

Phone: \_\_\_\_\_

Website: \_\_\_\_\_

Email: \_\_\_\_\_

Clinic/practice name: \_\_\_\_\_

Street address: \_\_\_\_\_

City: \_\_\_\_\_

Phone: \_\_\_\_\_

Website: \_\_\_\_\_

Email: \_\_\_\_\_

Clinic/practice name: \_\_\_\_\_

Street address: \_\_\_\_\_

City: \_\_\_\_\_

Phone: \_\_\_\_\_

Website: \_\_\_\_\_

Email: \_\_\_\_\_

*Please note: We will add your photo – taken from your website - to enhance the BADD directory.*

**Enclosed:** \_\_\_\_\_ cheque for \$50 made out to “BADD Treasurer”  
\_\_\_\_\_ copy of your current professional registration

Please mail to: BC BADD Society  
Box 325 – 5535 West Boulevard  
Vancouver BC V6M 3W6