Canadian Academy of Psychosomatic Medicine
L'Académie canadienne de médecine psychosomatique

Application for Membership

CANDIDATE, PLEASE NOTE: Your application will not be accepted without the following materials enclosed:

1. **Statement describing your current activities in consultation-liaison psychiatry/psychosomatic medicine**
2. **Payment made in full by cheque - $150 for Full/Associate members or $30 for Residents**

☐ **FULL MEMBER**. Psychiatrist actively engaged in consultation-liaison psychiatry, medical psychiatry, **and/or** psychosomatic medicine.

☐ **ASSOCIATE MEMBER**. Individual with advanced degree in a related field and actively engaged in consultation-liaison psychiatry, medical psychiatry, and / or psychosomatic medicine.

☐ **POSTGRADUATE FELLOW / RESIDENT / INTERN / STUDENT**

DEMOGRAPHICS *Please type or print*

FULL NAME OF CANDIDATE: _____ **Graduate degree(s):** _____

Preferred Mailing Address: _____

Date of Birth: _____

Telephone (cell)	Telephone (other)	Email

Current Professional Positions		
Title	**Institution & City**	**Dates**

SPECIALTY CERTIFICATION(S)

Royal College of Physicians and Surgeons of Canada in the Specialty of Psychiatry ☐

Or other; please specify _____

LICENSURE: Provide jurisdiction and licence number(s)

Have you ever been the subject of disciplinary action by any federal, state, or local professional licensing authority?

☐Yes (Please submit explanation) ☐No

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Past Professional Positions		
Employment following graduate education, in chronological order. Attach CV if necessary		
Institution and Location	**Appointments or Positions**	**Dates**

Education – Additional information may be supplied on your CV			
	Institution and Location	**Year Graduated**	**Degree attained**
Medical School			
Internship			
Residency			
Fellowship			
Other graduate education			
Post-graduate education			

Short Summary of your C/L or Psychosomatic Medicine work experience:

I understand that in order to evaluate my application, the Academy will review my credentials. I agree to cooperate in such review and allow others to provide information regarding my credentials. To the best of my knowledge, all information provided by me in this application is true and complete.

Signature of Applicant: _____ Date: _____

Return all requested materials to CAPM:

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(613) 234-2815 ▪ Fax: (613) 234-9857 ▪ capm@cpa-apc.org
www.capm-acmp.org

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