

MEDICAL OFFICE ASSISTANTS' ASSOCIATION OF BC

CHAPTER MEMBERSHIP APPLICATION FORM

Name in full: _____ Date: _____

Address:

Phone: (H) _____ (W) _____ (Fax) _____ Email _____

QUALIFICATIONS FOR MEMBERSHIP

- a) Employed in a Medical Facility and/or
- b) Completed a Health Care Education Program.
- c) Student membership, with no voting privileges, may be granted to students by Chapters, with fees at the Chapter's discretion.

a) Employed in a Medical Facility:

Present or last employer

Address _____

OR

b) Completed a Health Care Education Program:

Name of Health Care Education Program

Business School

OR

c) Student membership

Name of Health Care Education
Program _____

Business School _____ Date graduating _____

ANNUAL DUES: _____

Membership pins are available

**FOR FURTHER CHAPTER INFORMATION, CONTACT THE LOCAL CHAPTER
IN YOUR AREA**

Chapter contact information is listed on this website