AIMGBC

Membership Registration Form

First Name _____

Last Name _____

Address _____

City/State/Zip _____

Phone _____

Email _____

Year of graduation as physician _____

Year of graduation as specialist _____

Field of practice or specialty _____

Year passed MCCEE _____

Year passed MCCQE1 _____

Year passed MCCQE2 _____

Date you passed OSCE or NAC-OSCE in BC _____

Date you passed OSCE or NAC-OSCE in other province _____

Do you work in Health Care? _____

What is the name of your position? _____

Form Submission Date _____

Signature _____