



Association of International Physicians & Surgeons of Nova Scotia (AIPSN)

Membership Application

Personal Information

Full Name:				
<i>Last</i>	<i>Middle</i>	<i>First.</i>		
Address:				
<i>Street Address</i>			<i>Apartment/Unit #</i>	
<i>City</i>		<i>State</i>	<i>ZIP Code</i>	
Phone:		E-mail Address:		
Date of Birth:	Place of Birth:		Gender:	<input type="checkbox"/> F <input type="checkbox"/> M
Languages:				

Medical Education

Name of Medical Degree:	
Name of Degree Granting University:	
Year of Graduation:	
City:	Country:
Language of Instruction:	

Postgraduate Medical Education

Internship:	
Name of Medical School/Base Hospital:	
Dates on Internship:	

Medical Practice Experience

Discipline	Location	City	Country	Date (from – to)

Additional Qualifications

Completion of Medical Council of Canada Evaluating Examination	No <input type="checkbox"/>	Yes <input type="checkbox"/>	Year
Completion of Medical Council of Canada Qualifying Exam Part I	No <input type="checkbox"/>	Yes <input type="checkbox"/>	Year
Completion of Medical Council of Canada Qualifying Exam Part II	No <input type="checkbox"/>	Yes <input type="checkbox"/>	Year
Others:	No <input type="checkbox"/>	Yes <input type="checkbox"/>	Year
i.e. USLME (All three steps) <input type="checkbox"/> CAPP <input type="checkbox"/> Manitoba Exam <input type="checkbox"/> CSAT <input type="checkbox"/>			



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Authorization of Release of Information

Upon acceptance of my membership application, I understand that AIPSN will, from time to time, use information about my personal history and medical training in its advocacy role for International Medical Graduates. However, I understand that at such times, name will not be identified without prior permission from me by writing.

Date: _____

Name: _____

Signature: _____

***** Please attach a copy of your CV to this application.**

Please mail the application to:

AIPSN-NS
c/o MISA
Suite 201 ChebuctoPlace
7105 Chebucto Road
Halifax, Nova Scotia
B3L 4W8

Or send an electronic copy to:

aipsns@gmail.com