



Newfoundland and Labrador Association of Medical Radiation Technologists

APPLICATION FOR MEMBERSHIP

NAME : Mr./Mrs/Ms _____ CAMRT # _____

ADDRESS:

CITY/TOWN _____ **PROV:** _____ **POSTAL CODE:** _____

TELEPHONE: (H) _____ **(W)** _____

E-Mail: _____

DATE OF BIRTH: Day _____ Month _____ Year _____

Education: Please provide details of post-secondary education to current. Please include copies of certificates earned or diplomas received. (Use separate sheet if necessary)

Employment History: (Earliest to present if applicable and include dates please)

Dates (From-To)	Institution	City / Town	Manager/Supervisor

Please forward completed application and other documentation to:

NLAMRT
PO Box 29141
Torbay Rd. Post Office
St. John's, NL
Canada A1A 5B5

Signature:

Date of Application:

You will receive an invoice for applicable membership fees upon receipt and processing of this application.