Newfoundland and Labrador Association of Medical Radiation Technologists

NEW GRADUATE REGISTRATION FORM

Name:

Address:

City: ________________________

Postal Code

Phone Number Home __________________________ Work ________________________

Date of Birth: (D) ___ (M) ___ (Y) _______

Discipline: ____Radiography _____ Nuclear Medicine ____ Radiation Therapy ____ MRI

Place of Employment: (if applicable)

Hospital: ____

Health Care Board: ____

Email Address:

Signature:

Date:

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Please return this completed form to:

NLAMRT
Secretary/Treasurer
P.O. Box 29141, Torbay Road Post Office
St. John's, NL
Canada A1A 5B5

You will be contacted by mail or e-mail with the appropriate membership fees.

Please submit cheque or money order ***only and made payable to N.L.A.M.R.T.***
DO NOT SEND CASH BY MAIL!