Ontario Association of Medical Radiation Sciences
Canadian Association of Medical Radiation Technologists

CAMRT ACTRM

APPLICATION FOR MEMBERSHIP

Name: ☐Mr. / ☐Mrs. / ☐ Ms. / ☐ Miss	OAMRS/ CAMRT #

Address	City & Postal Code

Telephone (Bus.) _____ **Telephone (Mobile)** _____

Email _____

Date of Birth Year Month Day **Graduation date:** Year Month Day

Radiological Technologist ☐	Radiation Therapy ☐	Nuclear Medicine ☐	Magnetic Resonance ☐

Employment Information

Employer	Street Address	City	Postal Code

Membership Category

☐ Full Practice	☐ Non-practising

Payment Information

☐Credit Card ☐ VISA ☐ MasterCard ☐ AMEX Card Number: _____ Expiry Date: _____ CSC : _____	☐Cheque or Money order (Payable to OAMRS)

Payment Options

1. Mail: 415A - 175 Longwood Road, South Hamilton, ON L8P 0A1
2. Online: http://www.oamrs.org/payment-options-renewals-2016.shtml
3. Fax: 289-674-0037
4. Email: membership@oamrs.org

By proceeding with payment of your Membership dues, it is implied that you understand and consent to receiving all information from the OAMRS.

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