

MEMBERSHIP FORM



PERSONAL INFORMATION

FIRST NAME	LAST NAME	NOMINATION DATE
<input type="text"/>	<input type="text"/>	<input type="text"/>
HOME ADDRESS	CITY	POSTAL CODE
<input type="text"/>	<input type="text"/>	<input type="text"/>
TEL (HOME)	CELL	E-MAIL (PERSONAL)
<input type="text"/>	<input type="text"/>	<input type="text"/>

WORK INFORMATION

NAME OF EMPLOYER	TITLE	INTERIM MANAGER OR PERMANENT
<input type="text"/>	<input type="text"/>	<input type="text"/>
EMPLOYER'S ADDRESS	CITY	POSTAL CODE
<input type="text"/>	<input type="text"/>	<input type="text"/>
TEL (WORK)	EXTENSION	E-MAIL (WORK)
<input type="text"/>	<input type="text"/>	<input type="text"/>

ASSOCIATIONS AND/OR PROFESSIONAL ORDER OF WHICH YOU ARE A MEMBER

HOW DID YOU LEARN ABOUT APER?

WEBSITE INFO-CADRE MEMBER COLLEAGUE OTHER (SPECIFY):

By signing below, I am officially asking to join APER Health and Social Services. *

*You must not be in a dispute with your employer at the time of your membership

DATE

NOTE: You must also fill out the form authorizing your employer to automatically deduct APER's membership fee from your salary. Once duly completed please return the Membership Form and the Authorization for Deduction at Source directly to APER or give it to Human Resources who will forward it to us.