



CANADIAN PHLEBOTOMY TECHNICIANS GROUP INC.

P.O BOX 36060 NORTHGATE, BRAMPTON, ON L6S 6A3, CANADA

E-Mail: info@mycptg.ca Phone: 1 (905) 216-3339 Phone: 1 (416) 817-9516

CPTG MEMBERSHIP APPLICATION FORM

1. CANDIDATE INFORMATION

| | | | |
|----------------------------|--|------------------|--|
| TITLE: | | | |
| First NAME: | | | |
| LAST NAME: | | | |
| ADDRESS: | | | |
| CITY: | | PROVINCE: | |
| POSTAL CODE: | | COUNTRY: | |
| E-MAIL: | | | |
| PHONE: | | | |
| JOB TITLE/POSITION: | | | |
| PROF. DESIGNATION: | | | |
| MEMBERSHIP ID: | | | |

2. PAYMENT METHOD

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| CERTIFIED CHEQUE: | All cheques and bank drafts should be made payable to CANADIAN PHLEBOTOMY TECHNICIANS GROUP INC. and should be sent along with this application form. If paying by cheque, please note that we accept certified cheques only. | AMOUNT DUE CAD 129.00 <small>PLUS APPLICABLE TAXES</small> |
| BANK DRAFT: | | |
| BY CARD: | | |
| CARD TYPE: | | |
| CARD PROVIDER: | | |
| CARD NUMBER: | | |
| HOLDER'S NAME: | | |
| EXPIRY (MM/YY): | | CVV: |

I _____, authorize **CANADIAN PHLEBOTOMY TECHNICIANS GROUP INC.** to charge CAD 129.00 + applicable taxes to the credit card indicated in this authorization form. I understand that the amount being charged is the fee for annual CPTG membership. I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit card company.

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| By signing this form, I agree to all the terms and conditions of CANADIAN PHLEBOTOMY TECHNICIANS GROUP INC. | | |
| | DATE | SIGNATURE |