



Membership Renewal Application Form 2012

I hereby make application for Membership (see list below) in the Canadian Institute of Public Health Inspectors. This application implies that membership is to continue until resignation is tendered, or until membership is discontinued under the conditions contained in the By-Laws of the Institute.

CPHI(C) Certificate #: _____ Year Issued: _____ How many years have you been a member of CIPHI? _____

No Changes From Last Year Yes, Changes – See Below (Complete section below only if personal information has changed.)

* Name: _____ * Date of Birth: _____ / _____ / _____
Surname First Middle (For identification purposes) Day Month Year

Home Address: _____
Street City Province Postal Code

Phone #: _____ / _____ Email Address: _____
Area Code

Work Phone #: _____ / _____ Fax #: _____ / _____ Work Email Address: _____
Area Code Area Code

Present Employer: _____
Agency Street Address

Employer Address: _____ Postal Code: _____
City/Town Province

Code of Ethics - As a Member of the Canadian Institute of Public Health Inspectors, I acknowledge:

That I have moral obligations relating to my professional practice in return for the trust given to me by society. I am obliged to uphold the law and to act to protect the public's health, follow the Constitution, the Bylaws, the Standards of Practice of CIPHI, and conduct myself in a manner worthy of the environmental public health profession and practice in accordance with these fundamental principles and ethics including:

- Promoting Justice
- Being Accountable
- Maintaining Privacy & Confidentiality
- Promoting Evidence-Informed Decision Making
- Promoting Health, Well-Being & Collaboration
- Competent Practice

My signature hereon constitutes a realization of my personal commitment to the Code of Ethics of CIPHI.

* Signature: _____ * Date: _____

• Please check the type of membership you require:

Regular (see below) Student \$50.00 Retired \$50.00 Fraternal \$120.00 International \$105.00

* Please circle branch you wish to belong to below:

NOTE: Province in which you reside unless you live in Northwest Territories, Nunavut, Yukon or outside Canada

"By checking this box, the applicant/undersigned does not give permission for the Canadian Institute of Public Health Inspectors to provide his/her name and contact information to corporate/affiliate members of the Institute."

British Columbia	Alberta	Saskatchewan	Manitoba	Ontario	Québec	New Brunswick	Nova Scotia/PEI	Nfld/ Labrador
\$200.00	\$200.00	\$200.00	\$200.00	\$200.00	\$200.00	\$200.00	\$195.00	\$190.00

(Includes Registration)

* Payment is made by:

- Cheque
- Credit Card
- Money Order
- Employer (cheque attached)
- Payroll Deduction
- Spousal (2 PHIs/home)

— send forms together & deduct \$30 for one person, only one EHR subscription will be received.

Credit Card Type: Visa MasterCard American Express

Number on Card: _____ / _____ / _____ / _____

Expiry Date: ____ / ____

Name on Card: _____

Signature: _____

Please make cheques payable to CIPHI and forward your application by postal service to:

CIPHI, #720 – 999 W. Broadway, Vancouver, BC V5Z 1K5 Canada

Fax: 604-738-4080 or Phone: 604-739-8180 (Toll free: 1-888-245-8180)

