Membership Renewal Application Form 2010

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 #: _______/____________ 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 an obligation to the sciences and arts for the advancement of Public Health. I will uphold the standards of my profession, continually search for truths, and disseminate my findings; and I will strive to keep myself fully informed of the developments in the field of Public Health.

That I have an obligation to the Public whose trust I hold and I will endeavor to the best of my ability, to guard their interests honestly and wisely. I will be loyal to the profession and Institute to which I belong.

That the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition.

That being loyal to my profession, I will uphold the Constitution and By-Laws of the Canadian Institute of Public Health Inspectors and will, at all times, conduct myself in a manner worthy of my profession.

My signature hereon constitutes a realization of my personal responsibility to actively discharge these obligations."

* 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 ❑ **Associate** $130.00

* 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	Quebec	New Brunswick	Nova Scotia/PEI	Nfld/ Labrador
$195.00	$175.00	$175.00	$175.00	$175.00	$125.00	$175.00	$170.00	$165.00

(Includes Registration)

* Payment is made by:
- ❑ Cheque
- ❑ 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: ❑ 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)