

APPLICATION FOR MEMBERSHIP

Applicant Information:			
Title:	Last Name:	First Name:	Initial:
Degrees:		Academic Rank:	
Academic Department:		Academic Division:	

Contact Information:			
Room#:	Street Address:		
City:	Province:	Postal Code:	
Primary Phone#:		Fax:	
Secondary Phone#:		Pager:	
Email:		Web Address:	

Category of Membership:		
Category 1	Category 2	Category 3
<input type="checkbox"/> Scientist Level 1 <input type="checkbox"/> Scientist Level 2 <input type="checkbox"/> Scientist Level 3 <input type="checkbox"/> Clinician Scientist <input type="checkbox"/> Senior Clinician Scientist	<input type="checkbox"/> Associate Scientist <input type="checkbox"/> Associate Clinician Scientist <input type="checkbox"/> Sr. Associate Clinician Scientist	<input type="checkbox"/> Clinical Investigator <div style="background-color: #e0ffe0; text-align: center; padding: 2px;">Category 4</div> <input type="checkbox"/> Senior Scientist Emeritus <input type="checkbox"/> Adjunct Scientist <input type="checkbox"/> Consultant

Cluster Affiliation:				
Indicate Cluster affiliation(s) by ticking the appropriate box(es).				
In the case of multiple affiliations, applicants are required to indicate their primary (1 only) and secondary affiliation(s) and the % split between the groups (to a maximum of 100%)				
Clusters:	Primary Affiliation		Secondary Affiliation <i>(if applicable):</i>	
	√	% Alignment	√	% Alignment
Childhood Cancer & Blood Research.....	<input type="checkbox"/>	—	<input type="checkbox"/>	—
Developmental Neurosciences & Child Health.....	<input type="checkbox"/>	—	<input type="checkbox"/>	—
Diabetes, Nutrition & Metabolism				
- Diabetes.....	<input type="checkbox"/>	—	<input type="checkbox"/>	—
- Nutrition & Metabolism.....	<input type="checkbox"/>	—	<input type="checkbox"/>	—
Genetics & Health.....	<input type="checkbox"/>	—	<input type="checkbox"/>	—
Immunity in Health & Disease.....	<input type="checkbox"/>	—	<input type="checkbox"/>	—
Innovations in Acute Care & Technology.....	<input type="checkbox"/>	—	<input type="checkbox"/>	—
Reproduction & Healthy Pregnancy.....	<input type="checkbox"/>	—	<input type="checkbox"/>	—
CFRI Partner Organization:				
The Centre for Molecular Medicine and Therapeutics (CMMT)...	<input type="checkbox"/>	—	<input type="checkbox"/>	—

APPLICATION FOR MEMBERSHIP (cont.)

Supporting Documentation:

- Applicant's CV
 Two (2) page (max.) summary of applicant's research program
 Completed web profile
 Other (please detail):

It is agreed that the guidelines governing membership, as outlined in the "Child & Family Research Institute Membership Criteria" document, apply to this application and are hereby accepted by the applicant, the applicant's Department Chair and the R.I. Cluster / Program Leader.

Signatures:

Applicant: Signature: _____	Date: _____
Academic Department Chair: Signature: _____	Date: _____
Cluster / Program Leader: Signature: _____	Date: _____
Signature: _____	Date: _____
Signature: _____	Date: _____

The completed application form and supporting documents should be mailed to:

Allison Rintoul
Director, Research & Education Services
Child & Family Research Institute
Room A2-148, 950 West 28th Avenue
Vancouver BC V5Z 4H4.

For Research Institute Administration use only:

<i>Date application received:</i>	<i>Date:</i>
<i>Reviewed by Deputy Director:</i>	<i>Date:</i>
<i>Approved by Board of Directors:</i> <input type="checkbox"/> Yes <input type="checkbox"/> No	<i>Date:</i>
Acceptance letter sent to:	
<i>Applicant:</i>	<i>Date:</i>
<i>Cluster / Program Leader:</i>	<i>Date:</i>
<i>Department Chair:</i>	<i>Date:</i>