MEMBERSHIP APPLICATION
PARIM, Doctors Manitoba, CMA, RDoC

PARIM I.D. # _____ Residency Start Date_____
(assigned by Payroll)

Name _____
First Name Middle Initial Last Name

Male ☐ Female ☐ Date of Birth (D/M/Y)_____

Social Insurance Number _____
required for administration of Physician Retention Program Benefits

Program:_____ PGY LEVEL_____ Expected Date of Completion _____

Place of Graduation (undergrad) _____ Year of Graduation (undergrad) _____

Home Address _____

City/Town _____ Province_____ Postal Code_____

Telephone_____ Fax _____

E-Mail Address _____

Membership Agreement

I hereby apply for Membership in each of Doctors Manitoba, Canadian Medical Association ("CMA"), Professional Association of Interns and Resident of Manitoba ("PARIM") and Resident Doctors of Canada ("RDoC"). As a Member of each, I agree to be governed by their respective Constitution & Bylaws.

I understand how PARIM & Doctors Manitoba dues are assessed and authorize my employer to deduct from my pay all applicable dues, as determined by PARIM and Doctors Manitoba from time to time. I further authorize my employer to deduct from my pay at the direction of Doctors Manitoba any Doctors Manitoba group insurance premiums.

I freely and without coercion authorize PARIM exclusively to bargain collectively on my behalf with my employer.

Consent & Authorization

I understand that "personal information" includes, but is not limited to, my name, addresses, date/location of birth, gender, other demographic information, specialty, billing number(s), practice/billing profiles, contractual terms with, and financial compensation from, the Province of Manitoba (Manitoba Health and any Department, Agency, Crown Corporation or Regional Health Authority), University of Manitoba and any other employer or contractor including fee-for-service payments, salary and/or administrative, on-call and other stipends, and other compensation and benefits.

I authorize PARIM and Doctors Manitoba to access, collect and disclose my personal information for, and communicate with me (via phone, mail, email, text or fax) about, the following limited purposes:

- To determine my membership status in PARIM, Doctors Manitoba, CMA and RDoC and maintain my personal and professional contact information in the PARIM, Doctors Manitoba and CMA databases.
- To determine my eligibility for compensation and PARIM, Doctors Manitoba or CMA benefit programs, products and services including, but not limited to, the Maternity/Parental Benefits Program, New Car Program, insurance and other affinity programs.
- To develop and market PARIM, Doctors Manitoba or CMA benefit programs, products and services tailored to the interests of physicians and other eligible purchasers (e.g. family members).
- To represent me, my professional interests, and the interests of the profession, financial and otherwise, through advocacy, negotiation and arbitration and to communicate with me about it.

I understand that this consent/authorization will continue in full force until revoked by me in writing.

Signature _____ Date _____

Fax to: 985-5844
Mail to: 20 Desjardins Drive Winnipeg MB R3X 0E8