South Island Division of Family Practice
An FPSC initiative

#201 - 4480 West Saanich Rd, Victoria, BC V8Z 3E9
Phone: 250.658.3303 | Fax: 250.658.3304 | E-mail: info@sidfp.com

SIDFP Membership Enrollment

*** Required fields**

GENERAL INFORMATION:			
Salutation:			
First Name:*			
Last Name:*			
Suffix:			
Member Type:*	☐ Committee Partner ☐ Guest – BCMA ☐ Guest – Community ☐ Guest – GPSC ☐ Guest – Health Authority ☐ Guest – MOH ☐ Guest – Other	☐ Guest – Supplier ☐ Midwife ☐ Nurse – Practitioner ☐ Nurse – Registered ☐ Physician ☐ Physician – ERP ☐ Physician – Hospitalist	☐ Physician – Lead ☐ Physician – Locum ☐ Physician – Non-Member ☐ Physician – Resident ☐ Physician - Retired
Practice Community:*	☐ Brentwood Bay ☐ Central Saanich ☐ Colwood ☐ Esquimalt ☐ Langford ☐ Metchosin	☐ North Saanich ☐ Oak Bay ☐ Saanich ☐ Saanichton ☐ Sidney ☐ Sooke	☐ South Island - Committee Partner ☐ Vic West ☐ Victoria (South Island) ☐ View Royal ☐ Salt Spring Island
MSP Billing Number:		**CFPC Number:**	
Payable To:			

CONTACT INFORMATION:			
Preferred Email to be Listed in Division Contact Directory: *	☐ Work	☐ Home	☐ Division
Email:*	**Work:**		
	Home:		
	Division:		
Phone:*	**Preferred Phone:**	☐ Work ☐ Home ☐ Division	
	Work:		
	Home:		
	Cell:		
Fax Number:		**Pager Number:**	

Preferred address to be used for mailing purposes:*	☐ Work ☐ Home					
Clinic / Office Name:						
Practice Type:*	☐ Emergency ☐ Hospital ☐ Hospitalist ☐ Obstetric Clinic Only ☐ Office	☐ Office – no hospital privilege ☐ Office – with hospital privilege ☐ Other: _____ ☐ Specialist: _____ ☐ Walk-in Clinic				
Web Address:						
Work Address:	**Address 1:**					
	Address 2:					
	City:		**Province:**		**Postal Code:**	
Home Address:	**Address 1:**					
	Address 2:					
	City:		**Province:**		**Postal Code:**	

Do you have Committee or Board experience?

☐ No ☐ Yes Explain:_____

How long have you been working as a physician in the Victoria area?

_____ years

Are there areas of interest or special training of your practice?

In order to better understand our members, please identify any special interests you are currently involved in or would like to be involved in.

In order to better understand the issues affecting our members, please identify your main challenges with primary care in our region, or any projects or programs you are aware of that could support local primary care.

Please forward completed Membership Form to:

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