2019 PRACTICING MEMBERSHIP FORM

This application is for MAM membership from January 1, 2019 to December 31, 2019. Due November 30, 2018 with payment in full or post-dated cheques.

Name:

Mailing address:

Street address/PO Box

City *Province* *Postal Code*

Home phone no.:

Email address:

☐ **Full Membership (Registered Practicing Midwives*)** **$730.00**

- ☐ **Full amount:** $730.00 post-dated Jan 1 2017
- ☐ **Payment Plan:** 3 payments ($280 Jan 1 2017, $225 Mar 1 2017, $225 May 1 2017)

☐ **Discounted rate for Board members (Registered Practicing Midwives*) $630.00**

- ☐ **Full amount:** $630.00 post-dated Jan 1 2017
- ☐ **Payment Plan:** 3 payments ($280 Jan 1 2017, $225 Mar 1 2017, $125 May 1 2017)

***Proof of current registration with CMM must be presented on request of MAM.**
PRIVACY STATEMENT - The Midwives Association of Manitoba will not release your personal information to another person or agency without your signed and informed consent.

RELEASE of INFORMATION CONSENT to HIROC and CAM and STATEMENT of UNDERSTANDING RE: INSURANCE

☐ As a member of MAM, I am fully aware that MAM may release my name and contact information to the Canadian Association of Midwives and to HIROC. Both of these agencies are integral components to my MAM membership and neither will distribute my personal information without notifying MAM.

☐ As a member of MAM, I understand that I may be covered by supplementary legal defense insurance through HIROC. If I fail to pay my fees on time, my insurance coverage will lapse without further notification. A $25 fee will be applied per late or NSF payment.

Signature: **Date:**

For Office Use Only: Date received ______________ (postmark or other________) Initial _____

Option 1: Etransfer to mametransfer@gmail.com with password: placenta
PLEASE COMPLETE AND RETURN THIS FORM TO: midwivesofmanitoba@gmail.com

Option 2: Cheques payable to MIDWIVES ASSOCIATION OF MANITOBA INC.
Mail this form & cheque to: Midwives Association of Manitoba, 3973 Redwood Postal Office, Winnipeg, MB R2W 5H9

2019 PRACTICING MEMBERSHIP FORM

Membership Insurance Application Form
Legal Defense Only – 2017
Registered practicing midwives

1. **Legal name of applicant**

2. **AKA name (if applicable)**

3. **Mailing address**

4. **College Registration No.**

5. **RHA/Employer**

6. **Work address (site address)**

7. **Declaration and signature**

I declare that to the best of my knowledge, the statements set forth herein are true and further agree that if any significant change is discovered between the date of this application form and the effective date of the policy, which would render this application form inaccurate or incomplete, notice of such change will be reported immediately in writing to the Insurer. Signing this application does not bind the Applicant or Insurer to complete the insurance, but it is agreed that this form shall be the basis of the contract should a policy be issued and this form will be attached to and become part of the policy.

Date: **Signature of applicant:**

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