

PROFESSIONAL PARAMEDIC ASSOCIATION OF OTTAWA
PLEASE PRINT CLEARLY

FULL NAME													
ADDRESS													
CITY						PROVINCE			POSTAL CODE				
DATE OF BIRTH		Y	Y	Y	Y	M	M	D	D	SEX		COLLEGE OR CORPORATION NAME	
PHONE													
PAGER													
CELLULAR													
EMAIL 1													
EMAIL 2													
AUTHORIZED SIGNATURE								DATE (YYYY-MM-DD)					

DO YOU WANT TO VOLUNTEER?

YES NO

PLEASE SELECT YOUR MEMBERSHIP
(ANNUAL DUES PERIOD: JAN 01 - DEC 31)

STUDENT
(\$60/year) **CORPORATE**
(\$600/year)



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**STUDENT AND CORPORATE
MEMBERSHIP CARD**