



Membership Registration Form

Please accept my registration in the Canadian Society of Clinical and Refractive Optometry for the 2009 calendar year

Name

Title _____ First _____ Last _____

Mailing Address

Number _____ Street _____ Suite _____

City _____ Province _____ Postal Code _____

Contact Information

Office Phone (____) _____ Fax (____) _____

E-Mail _____

Professional License

Province _____ Number _____

Please complete this form and include a cheque for \$100 made payable to the CSCRO and mail it today to:

Canadian Society of Clinical and Refractive Optometry

3535 St Charles Blvd. Suite 201, Kirkland, Quebec, H9H 5B9