



*The Medical Professionals Association
Of Trinidad and Tobago
86 Main Road, Chaguana
Tel. 671-6557; Fax: 671-9483*

MEMBERSHIP APPLICATION FORM (please fill out in block letters)

NAME: _____
FIRST* MIDDLE* SURNAME*

HOME ADDRESS: _____

D.O.B. _____ TELEPHONE: _____
DD/MM/YYYY MOBILE* HOME*

EMAIL: _____
PRIMARY ALTERNATE

EMPLOYED AS: INTERN [] H.O. [] REG [] SMO []
MOI [] CMOH [] MCOS [] PCP I []
PCP II [] OTHER _____

IN THE _____
DEPARTMENT & HOSPITAL NAME/HEALTH CARE FACILITY

BY THE: NWRHA [] SWRHA [] NCRHA [] TRHA [] ERHA [] MOH []

I hereby apply for membership in the Medical Professionals Association of Trinidad and Tobago (MPATT) in accordance with the rules of the Association. I am not a member of any other Trade Union or affiliated labour Association. Please find enclosed the entrance fee of TT\$50.00. I hereby declare that the above information is true.

NAME OF WITNESS** SIGNATURE OF WITNESS APPLICANT'S SIGNATURE*** DATE

* THESE FIELDS MUST BE COMPLETED ** WITNESS MUST BE A REGISTERED MPATT MEMBER
***PLEASE INCLUDE YOUR VALID MEMBERSHIP ID FROM MEDICAL BOARD OF T&T.

MPATT AUTHORIZATION FOR DEDUCTION FROM SALARY

NAME: _____ DATE: _____

POST: _____ DEPARTMENT: _____

HOSPITAL/FACILITY: _____ RHA: _____

Dear Paysheet Clerk of _____
DEPARTMENT & HOSPITAL NAME/HEALTH CARE FACILITY

Please deduct from my salary MPATT subscription dues in the sum of TT\$100.00 from the month of _____ in the year _____ and thereafter at the rate of TT\$100.00 each month.

SIGNATURE OF WITNESS APPLICANT'S SIGNATURE DATE

THE AMOUNTS DEDUCTED ARE TO BE PAID TO THE MEDICAL PROFESSIONALS ASSOCIATION OF TRINIDAD AND TOBAGO, #86 MAIN ROAD, CHAGUANAS.