CANADIAN FERTILITY AND ANDROLOGY SOCIETY
SOCIÉTÉ CANADIENNE DE FERTILITÉ ET D'ANDROLOGIE

TRAINEE ATTESTATION FORM

Graduate students, medical residents and fellows must submit this completed form when applying for a CFAS membership.

Surname ________________________________ First Name ______________________________

Affiliation ____

Email ____________________________________ Date ________________________________

Supervisor's Name (please print) ____

Supervisor's signature ____

1719 rue Grand Trunk • Suite 301 • Montreal, QC • H3K 1M1 • Canada
Tel. 514.524.9009 • Fax 514.524.2163 • info@cfas.ca • www.cfas.ca