



CCTX APPLICATION FORM -- HEALTHCARE INSTITUTIONS

ORGANIZATION AND CONTACT INFORMATION

Healthcare Facility Name:

Address:

City:

Province:

Postal Code:

Incorporation/Registration Number:

Location of Incorporation/Registration:

Web Site URL:

Annual Budget:

Contact Name:

Contact Title:

Office Address:

City:

Province:

Postal Code:

Phone:

E-mail:

CATEGORY OF MEMBERSHIP

**Category of membership is determined by healthcare institution's annual budget.
Annual CCTX fees vary by category.**

Healthcare Associate

Choose level (as described below):

1. Healthcare Associate (Platinum) - \$750M+ Annual Budget
2. Healthcare Associate (Gold) - \$500M to \$749M Annual Budget

3. Healthcare Associate (Silver) - \$200M to \$499M Annual Budget
4. Healthcare Associate (Bronze) - \$50M to \$199M Annual Budget
5. Healthcare Associate (Entry) - Below \$50M Annual Budget

MISSION STATEMENT

CCTX will support the sharing and analytics of cyber threat information across sectors and with other sharing hubs to help protect Canadian businesses, governments, and consumers, and strengthen Canada's economic prosperity.

SIGNATURE

I authorize the verification of the information provided on this form.

Name and Title of authorized representative

Signature

Date