



APPLICATION FORM

General Information: <i>INSTRUCTIONS Write in clear block letters.</i>	
Family name:	First name:
Date of birth:	Place of birth:
Languages spoken :	
Sex: F <input type="checkbox"/> M <input type="checkbox"/>	
Are you a member of another association or gathering? Y <input type="checkbox"/> N <input type="checkbox"/>	
If so, the name and membership number:	
How have you heard about the ACTMD?	
Do you do house calls? Y <input type="checkbox"/> N <input type="checkbox"/>	
Do you offer treatments within companies? Y <input type="checkbox"/> N <input type="checkbox"/>	
Do you work with children? Y <input type="checkbox"/> N <input type="checkbox"/> teenagers? Y <input type="checkbox"/> N <input type="checkbox"/>	
Would you be interested to participate in workshops? Y <input type="checkbox"/> N <input type="checkbox"/>	
You would be interested to write articles? Y <input type="checkbox"/> N <input type="checkbox"/>	
Have you ever been recognized guilty of a criminal malpractice? Y <input type="checkbox"/> N <input type="checkbox"/>	
If so, specify nature and year of this malpractice:	
Have you been expelled or suspended from an organism or other professional order? Y <input type="checkbox"/> N <input type="checkbox"/>	
If so, specify reasons as well as year of being expelled or suspended:	

Home address:	
Address:	App.:
City:	Province:
Postal code:	

Business address <input type="checkbox"/> Same as home address:	
Address:	App.:
City:	Province:
Postal code:	

Phone number(s)	
Home:	Office:
Cell phone:	Pager
Fax:	E-mail:
WEB Site:	

Specialty	
Acupressure: <input type="checkbox"/> Aromatherapy: <input type="checkbox"/> Reiki: <input type="checkbox"/> Digitopuncture: <input type="checkbox"/>	
Others	

APPLICATION FORM (continuation)

Profession							
Massage therapist	<input type="checkbox"/>	Techniques:					
Naturopath	<input type="checkbox"/>	Kinesitherapist	<input type="checkbox"/>	Homeopath	<input type="checkbox"/>	Acupunctur	<input type="checkbox"/>
Naturopath	<input type="checkbox"/>	Physiotherapist	<input type="checkbox"/>	Orthotherapist	<input type="checkbox"/>	Kinesiologist	<input type="checkbox"/>
Chiroprator	<input type="checkbox"/>	Osteopath	<input type="checkbox"/>	Physical rehabilitation therapist (PRT)	<input type="checkbox"/>		
Others:							

Geographic location (choose only one)					
New-Brunswick	<input type="checkbox"/>	Ontario	<input type="checkbox"/>	North of Quebec	<input type="checkbox"/>
Estrie	<input type="checkbox"/>	Outaouais	<input type="checkbox"/>	Saguenay/Lac St-Jean	<input type="checkbox"/>
Gaspésie/I.D.M.	<input type="checkbox"/>	Chaudière/Appalache	<input type="checkbox"/>	Estrie	<input type="checkbox"/>
Quebec City	<input type="checkbox"/>	Laval	<input type="checkbox"/>	Bas St-Laurent	<input type="checkbox"/>
Côte-Nord	<input type="checkbox"/>	Lanaudière	<input type="checkbox"/>	Mauricie/Bois Franc	<input type="checkbox"/>
Abitibi/Témiscamingue	<input type="checkbox"/>	North-Shore	<input type="checkbox"/>	Laurentiens	<input type="checkbox"/>
Montréal	<input type="checkbox"/>	Mtl/West-Island	<input type="checkbox"/>	Mtl/Snowdon-C.D.N.	<input type="checkbox"/>
Mtl/Sud-Ouest	<input type="checkbox"/>	Mtl/Westmount	<input type="checkbox"/>	Mtl/Outremont	<input type="checkbox"/>
Mtl/Villeray-Pte. Patrie	<input type="checkbox"/>	Mtl/Verdun-I.D.S	<input type="checkbox"/>	Mtl/Lasalle	<input type="checkbox"/>
Mtl/Hochelaga-Maisonneuve	<input type="checkbox"/>	Mtl/Riv. Des Prairies	<input type="checkbox"/>	Mtl/St-Laurent	<input type="checkbox"/>
Mtl/Rosemont	<input type="checkbox"/>	Mtl/N.D.G.	<input type="checkbox"/>	Mtl/Centre-Sud	<input type="checkbox"/>
Mtl/St-Michel	<input type="checkbox"/>	Mtl/Downtown	<input type="checkbox"/>	Mtl/East	<input type="checkbox"/>
Mtl/Anjou	<input type="checkbox"/>	Mtl-Nord	<input type="checkbox"/>	Mtl/Plateau	<input type="checkbox"/>
Mtl/Ahuntsic	<input type="checkbox"/>	Mtl/Mercier	<input type="checkbox"/>		
Others:					

To become a member :

- Must be aged 18 years or more
- Must hold a high school diploma (or equivalent) or have relevant experience
- Must be a Canadian citizen or have the Canadian right of residency or have a valid Canadian work permit delivered by Canada Immigration.

To become a member, you must send us the following documents :

- Copy of diploma and attestation of marks
- Copy of birth certificate or valid passport
- Proof of Canadian citizenship or Canadian residency (if necessary)
- Proof of valid work permit (if necessary)
- One picture - passport format
- Copy of resume

Note : All documents sent to the ACTMD will not be returned to the recipient. If your application is not accepted, all documents will be destroyed properly.



WEB PUBLISHING CONSENT

I hereby allow the Canadian Association of Therapists in Complementary Medicine to publish my name and phone number on the Web site www.actmd.org under the members' subheading for public use.

I understand that the ACTMD is not responsible for the nature of calls members may receive.

Please note that this service has no charge and is not obligatory. ACTMD has 30 days to publish your name and retains the right to remove the name of members whose file has been closed for any reason.

Consequently, I, member, certify and acknowledge have read and understood each and every obligations of the present contract.

Signed on (date) _____

Signature _____

Name (in capital letters) _____

Phone number to be publish _____

City to be publish (1 only) _____

E-Mail _____

Web site _____

Geographic location (choose only one)					
New-Brunswick	<input type="checkbox"/>	Ontario	<input type="checkbox"/>	North of Quebec	<input type="checkbox"/>
Estrie	<input type="checkbox"/>	Outaouais	<input type="checkbox"/>	Saguenay/Lac St-Jean	<input type="checkbox"/>
Gaspésie/I.D.M.	<input type="checkbox"/>	Chaudière/Appalache	<input type="checkbox"/>	Estrie	<input type="checkbox"/>
Quebec City	<input type="checkbox"/>	Laval	<input type="checkbox"/>	Bas St-Laurent	<input type="checkbox"/>
Côte-Nord	<input type="checkbox"/>	Lanaudière	<input type="checkbox"/>	Mauricie/Bois Franc	<input type="checkbox"/>
Abitibi/Témiscamingue	<input type="checkbox"/>	North-Shore	<input type="checkbox"/>	Laurentiens	<input type="checkbox"/>
Montérégie	<input type="checkbox"/>	Mtl/West-Island	<input type="checkbox"/>	Mtl/Snowdon-C.D.N.	<input type="checkbox"/>
Mtl/Sud-Ouest	<input type="checkbox"/>	Mtl/Westmount	<input type="checkbox"/>	Mtl/Outremont	<input type="checkbox"/>
Mtl/Villeray-Pte. Patrie	<input type="checkbox"/>	Mtl/Verdun-I.D.S	<input type="checkbox"/>	Mtl/Lasalle	<input type="checkbox"/>
Mtl/Hochelaga-Maisonneuve	<input type="checkbox"/>	Mtl/Riv. Des Prairies	<input type="checkbox"/>	Mtl/St-Laurent	<input type="checkbox"/>
Mtl/Rosemont	<input type="checkbox"/>	Mtl/N.D.G.	<input type="checkbox"/>	Mtl/Centre-Sud	<input type="checkbox"/>
Mtl/St-Michel	<input type="checkbox"/>	Mtl/Downtown	<input type="checkbox"/>	Mtl/East	<input type="checkbox"/>
Mtl/Anjou	<input type="checkbox"/>	Mtl-Nord	<input type="checkbox"/>	Mtl/Plateau	<input type="checkbox"/>
Mtl/Ahuntsic	<input type="checkbox"/>	Mtl/Mercier	<input type="checkbox"/>		
Autres: _____					



EXTRACT OF THE CHARTER AND THE STATUTES OF THE ACTMD Details of some regulations

This document must be signed and returned with your membership copy

1. *A member must conform to the rules from the Charter and Statutes of the ACTMD;*
2. *The membership fee is payable on the anniversary date of your subscription. The member has thirty (30) days to pay its subscription. After this delay, if no agreement has been decided between the two (2) parties, the member's file will be closed and the member will therefore lose all of his privileges;*
3. *The orders for receipts and other articles must be paid within thirty (30) days following the reception of the order. Should the contrary occur, the member will lose his credit privilege and will have to pay any other purchase either by certified cheque, money order or credit card. A 2% late fee will then apply;*
4. *A member must inform the ACTMD about any change of address or telephone number. Fees will be charged if we have to proceed with a second mailing due to a wrong address;*
5. *A member must only practice the discipline for which he was formed and graduated. The professional insurance will not cover an act for which a therapist is not certified;*
6. *The member's certificate must be displayed for viewing;*
7. *The membership fee is not refundable.*

A member will lose his membership title:

1. *For not having paid his renewal on the anniversary date of his subscription;*
2. *For not having made the follow-up of his file, not mentioning any change of address, telephone number or email;*
3. *If the member has been expelled from another professional association, recognized or not.*

The members as well as the insurance companies will be informed of any case of suspension or expulsion. The Association reserves the right to inform the public, by other means, of the suspension or expulsion of a member.

A member that has been removed from the Association will lose all of its privileges.

The certificate and the membership card remain the property of the ACTMD and must be sent back to the Association at the moment of the expulsion, resignation, suspension or file closure. A fee of \$75.00 will be applied for certificates not being returned within thirty (30) days following the expulsion, resignation, suspension or file closure.

I understand that other regulations could be added and I agree to respect them as soon as I will be advised.

I understand the content to these regulations and I commit myself, by the present contract, to respect them under risk of penalty.

N.B.: For a complete version or any other information concerning the Association, you may consult our Website at the following address: www.actmd.org or call us at (514) 648-8111 / toll free number: 1-866-648-8111.

Signature : _____

Date : _____

At the ACTMD, we pay particular attention to the environment

