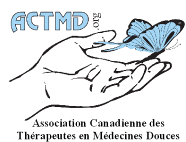

APPLICATION FORM

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

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

Business address 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:	Aromatherapy:	Reiki:	Digitopuncture:
Others			

APPLICATION FORM
(continuation)

Profession

Massage therapist	Techniques: ___		
Naturopath	Kinesitherapist	Homeopath	Acupunctor
Naturotherapist	Physiotherapist	Orthotherapist	Kinesiologist
Chiroprator	Osteopath	Physical rehabilitation therapist (PRT)	

Others:

Geographic location (choose only one)

New-Brunswick	Ontario	North of Quebec
Estrie	Outaouais	Saguenay/Lac St-Jean
Gaspésie/I.D.M.	Chaudière/Appalache	Estrie
Quebec City	Laval	Bas St-Laurent
Côte-Nord	Lanaudière	Mauricie/Bois Franc
Abitibi/Témiscamingue	North-Shore	Laurentiens
Montérégie	Mtl/West-Island	Mtl/Snowdon-C.D.N.
Mtl/Sud-Ouest	Mtl/Westmount	Mtl/Outremont
Mtl/Villeray-Pte. Patrie	Mtl/Verdun-I.D.S	Mtl/Lasalle
Mtl/Hochelaga-Maisonneuve	Mtl/Riv. Des Prairies	Mtl/St-Laurent
Mtl/Rosemont	Mtl/N.D.G.	Mtl/Centre-Sud
Mtl/St-Michel	Mtl/Downtown	Mtl/East
Mtl/Anjou	Mtl-Nord	Mtl/Plateau
Mtl/Ahuntsic	Mtl/Mercier	

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.
- By having mastered one of Canada's two (2) official languages, French and English

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.

APPLICATION FORM
(continuation)

I choose to pay in one payment– For one year					
40.00$	File opening[1]				
75.00$	Practical evaluation[1] (if require)				
165.00$	Membership fees 1 year				
	Total				
Amount to be paid:	Cash / Money order	Cheque	VISA	MasterCard	AMERICAN EXPRESS
Credit card #		Name of credit card holder:			
Expiry date:		Issue date:			

I choose to pay in one payment – For two years					
40.00$	File opening[1]				
75.00$	Practical evaluation [1]				
305.00$	Membership fees 2 years (discount of 25$)				
	Total				
Amount to be paid:	Cash / Money order	Cheque	VISA	MasterCard	AMERICAN EXPRESS
Credit card #		Name of credit card older:			
Expiry date:		Issue date:			

I undersigned, certify:

- I have read and understand the terms of my adhesion request;
- I am the solicitor and that all information included in my request form are truthful and accurate;
- I assure that all the diplomas, certificates, attestations of notes, documents and information provided to the ACTMD are truthful.
- I understand the code of ethics of the Canadian Association of Therapists in Complementary Medicine and agree to comply with the rules of this code of ethics and toward the rules of the Association.
- I freely consent and understand that ACTMD keeps on file all the information which I shall send in a written, oral, computerized way or any other form.
- I acknowledge that all practitioner's documents or membership certificate (s), statements are the ACTMD property. In the eventuality and for whatever reasons that I am no longer member, I engage myself to return to the head office the certificate (s), the practitioner's statements or any other documentation asked by the direction of ACTMD within ten (10) days of the cancellation of my status of member.
- I authorize the ACTMD to pass on to the general public (for reference only) or to authorities (insurers, police) the pertinent information from my file.
- It is understood that these informations remain confidential.

Date: __________ Signature: ______________________________________

[1] There are no fees for reviewing your academic record and determining course equivalencies (prior learning assessment and recognition). Processing fees for opening your file as well as practical assessment fees, if applicable, are non-refundable.

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	Ontario	North of Quebec
Estrie	Outaouais	Saguenay/Lac St-Jean
Gaspésie/I.D.M.	Chaudière/Appalache	Estrie
Quebec City	Laval	Bas St-Laurent
Côte-Nord	Lanaudière	Mauricie/Bois Franc
Abitibi/Témiscamingue	North-Shore	Laurentiens
Montérégie	Mtl/West-Island	Mtl/Snowdon-C.D.N.
Mtl/Sud-Ouest	Mtl/Westmount	Mtl/Outremont
Mtl/Villeray-Pte. Patrie	Mtl/Verdun-I.D.S	Mtl/Lasalle
Mtl/Hochelaga-Maisonneuve	Mtl/Riv. Des Prairies	Mtl/St-Laurent
Mtl/Rosemont	Mtl/N.D.G.	Mtl/Centre-Sud
Mtl/St-Michel	Mtl/Downtown	Mtl/East
Mtl/Anjou	Mtl-Nord	Mtl/Plateau
Mtl/Ahuntsic	Mtl/Mercier	
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 application

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 others 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

6650 rue de la Bataille, La Prairie (Québec) J5R 0K9
Appels locaux: (514) 648-8111 / No. sans frais:1-866-648-8111
www.actmd.org