



# APPLICATION FORM

<b>General Information:</b> <i>INSTRUCTIONS Write in clear block letters.</i>	
<b>Family name:</b>	<b>First name:</b>
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:	

<b>Home address:</b>	
Address:	App.:
City:	Province:
Postal code:	

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

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



## APPLICATION FORM (continuation)

<b>Specialization</b>			
Smoking	<input type="checkbox"/>	Hypno-anaesthesia	<input type="checkbox"/>
Weight management	<input type="checkbox"/>	Hypno-birth	<input type="checkbox"/>
Pedo-hypnosis	<input type="checkbox"/>	Rebirth	<input type="checkbox"/>
Others (clarify and include diplomas):			
Do you provide personalized cassettes to your clients?			
Do you provide pre-recorded cassettes to your clients?			

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

**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)

<b>I choose to pay in one payment – For one year</b>	
<input type="checkbox"/> 40.00\$	File opening <sup>1</sup>
<input type="checkbox"/> 75.00\$	Practical evaluation <sup>1</sup> (if require)
<input type="checkbox"/> 165.00\$	Membership fees 1 year
<b>Total</b>	
Amount to be paid:	<input type="checkbox"/> Cash / Money order <input type="checkbox"/> Cheque <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Credit card #	Name of credit card older:
Expiry date:	Issue date:

<b>I choose to pay in one payment – For two years</b>	
<input type="checkbox"/> 40.00\$	File opening <sup>1</sup>
<input type="checkbox"/> 75.00\$	Practical evaluation <sup>1</sup> (if require)
<input type="checkbox"/> 305.00\$	Membership fees 2 years (discount of 25\$)
<b>Total</b>	
Amount to be paid:	<input type="checkbox"/> Cash / Money order <input type="checkbox"/> Cheque <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
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: \_\_\_\_\_

<sup>1</sup> 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](http://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 \_\_\_\_\_

<b>Geographic location (choose only one)</b>					
New-Brunswick	<input type="checkbox"/>	Ontario	<input type="checkbox"/>	North of Quebec	<input type="checkbox"/>
Etrie	<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"/>	Etrie	<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 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](http://www.actmd.org) or call us at (514) 648-8111 / toll free number: 1-866-648-8111.

Signature : \_\_\_\_\_

Date : \_\_\_\_\_

