



APPLICATION FORM

General Information: <i>INSTRUCTIONS Please write in block capitals or type.</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:	



APPLICATION FORM (continuation)

Specialization	
Cigarette addiction <input type="checkbox"/>	Obesity <input type="checkbox"/>
Drug addiction <input type="checkbox"/>	Psychological disorder <input type="checkbox"/>
Psychotherapy training <input type="checkbox"/>	Food disorder <input type="checkbox"/>
Relationship helping training <input type="checkbox"/>	Regressions <input type="checkbox"/>
Rebirth <input type="checkbox"/>	Past lives <input type="checkbox"/>
	Hypno-anaesthesia <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?	

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"/>		
Autres:			

You must be aged 18 years or more and be a Canadian citizen or have the right of residency

In order to become a member:




- Enclose copy of diploma and attestation of marks;
- Enclose a copy of your birth certificate;
- Enclose one picture in passport size;
- Enclose a copy of resume.




Requests from persons not born or native from Canada, please include a proof of citizenship or legal residency.










To become a student member:

- Enclose a copy or a proof of your inscription at a school accredited by ACTMD;
- Enclose 2 current pictures passport size;
- Enclose a copy of resume.

APPLICATION FORM (continuation)

I choose to pay in one payment– For one year			
<input type="checkbox"/>	55.00\$	File opening ¹	
<input type="checkbox"/>	30.00\$	File opening ¹ if you are already a student member	
<input type="checkbox"/>	75.00\$	Practical evaluation ¹	
<input type="checkbox"/>	150.00\$	Membership fees 1 year	
Total			
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 choose to pay in one payment – For two years			
<input type="checkbox"/>	55.00\$	File opening ¹	
<input type="checkbox"/>	30.00\$	File opening ¹ if you are already a student member	
<input type="checkbox"/>	75.00\$	Practical evaluation ¹	
<input type="checkbox"/>	275.00\$	Membership fees 2 years	
Total			
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 choose to pay in 3 consecutive monthly payment – For one year			
<input type="checkbox"/>	55.00\$	File opening ¹	
<input type="checkbox"/>	30.00\$	File opening ¹ if you are already a student member	
This amount will be paid:		<input type="checkbox"/> Cash / Money order <input type="checkbox"/> Cheque	<input type="checkbox"/>  <input type="checkbox"/>  <input type="checkbox"/> 
<input type="checkbox"/>	75.00\$	Practical evaluation ¹	
This amount will be paid:		<input type="checkbox"/> Cash / Money order <input type="checkbox"/> Cheque	<input type="checkbox"/>  <input type="checkbox"/>  <input type="checkbox"/> 
<input type="checkbox"/>	50.00\$	1 st payment of the membership fees (The 2 others payments will be automatically deducted for the other months)	
These amounts will be paid:		<input type="checkbox"/>  <input type="checkbox"/>  <input type="checkbox"/> 	
Total			
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 Examination and file opening fees are not 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	<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 STATUTES OF THE ACTMD Precision on some rules

This document must have signed and have returned with your form of membership

1. A member must conform to the rules from the Chart and Statute of ACTMD.
2. *1.13.3* The membership fee is payable every year on your adhesion anniversary date. A member has 30 days to pay their contribution. After this delay, if no arrangement has been taken between the two parties, the member's file will be closed and he will therefore lose all privileges.
3. *1.14.1* The orders for receipts and other articles must be paid within 30 days following of the reception of the order. Should the contrary occur, the member will lose his credit privilege. A 2% late fee will be applied.
4. *1.8.4.3* A member must inform the ACTMD about any change of address or telephone number. The association won't search for these coordinates.
5. A member must only practice the discipline for which he was formed and graduated. The professional insurance won't cover an act for which a therapist is not certified and the customer will not be refunded for the treatment.
6. The member's certificate must be displayed publicly.

A member loses his/her membership title:

1. *1.8.4.3* By not doing the following-up of their file, not mentioning change of address, telephone number, email or credit card numbers for annual payments.
2. The members as well as the insurances companies will be informed of any case of suspension or expulsion. The association reserves the right to inform the public, by other means, of this suspension or expulsion.

A radiated member is not entitled to the association's privileges.

The certificate and the membership card remain the property of the ACTMD and must be sent back to us at the moment of the expulsion, the resignation or if the file is closed. A fee of 75.00\$ will be applied for certificates not returned within 30 days following the expulsion, suspension, resignation or closing of the file.

I understand that other regulations may be added and I promise to respect them at the moment that I will be informed.

I understand the contents to these regulations and I commit myself by the present contract to respect them under risk of sanction or penalty

N.B.: For a complete version, or any other information concerning the association, you may consult our Web site 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

