



## APPLICATION FORM

Please complete this form in **BLOCK CAPITALS** and send with your cheque (payable to the Association for Classical Manipulation) to the Membership Secretary.  
(Please check the list on Page 2 for other required documents to support your application)

Title: (Mr/Mrs/Miss/Ms) \_\_\_\_\_ First name(s) \_\_\_\_\_ Surname \_\_\_\_\_

Forename and surname for use on membership certificate: \_\_\_\_\_

Address \_\_\_\_\_

County \_\_\_\_\_

Postcode \_\_\_\_\_

Telephone (home) \_\_\_\_\_

Telephone (work) \_\_\_\_\_

Mobile \_\_\_\_\_

Email Address \_\_\_\_\_

Website \_\_\_\_\_

Type of Membership applied for (please circle):                      Member                      Associate                      Student                      Non-Practicing

Professional or other qualifications held:

Qualification \_\_\_\_\_ College/course details \_\_\_\_\_ Dates of course \_\_\_\_\_

Therapies/techniques (other than classical manipulation) practiced:

Have you ever applied for, or been a member of, any other professional body in the past? If the answer to either question is YES, please give details.

Name of Association/Organization \_\_\_\_\_ Dates of membership \_\_\_\_\_ Level of membership \_\_\_\_\_

Have you applied for membership of any other professional body and, if so, have you been refused or expelled from such membership? If so please give details.

Insurance

Please give details of previous/existing professional indemnity insurance related to your McTimoney training course or any other therapy/technique practiced. Also any claims made against you.

Cover provided for (e.g. therapy work/training) \_\_\_\_\_ Type of cover (claims made/claims occurrences/other) \_\_\_\_\_ Dates of period of cover \_\_\_\_\_

Details of McTimoney training:

Date qualified \_\_\_\_\_ School/college \_\_\_\_\_

Please indicate whether or not you intend to practice abroad. If so in which country?

*Inspired by and based upon the philosophy of John McTimoney*

The association is affiliated with The General Regulatory Council for Complementary Therapies





## DECLARATION TO BE COMPLETED BY THE APPLICANT:

I \_\_\_\_\_ having read and understood the Constitution, the Code of Ethics and Disciplinary Procedure of the Association for Classical Manipulation, do apply for membership of the Association. I confirm that to the best of my knowledge the information given on this form is correct.

I also confirm that I have read and understood Section 32 (i) of the Chiropractors Act 1994 and I do not hold myself out to be, or call myself, a chiropractor, chiropractic practitioner, chiropractitioner, chiropractic physician, or any other kind of chiropractor, either explicitly or by implication, unless registered with the General Chiropractic Council.

I agree to abide by the Standards of Practice, Continuing Professional Development requirements and Code of Ethics of the Association for Classical Manipulation.

**Signed**

**Date**

NB: The information provided on this form will be held on a database by the ACM which may, at some time, be registered as a data user under the Data Protection Act. In that event you would be entitled in law to be told whether any personal data is held on you and to be supplied with a copy of all such information. The Association would be entitled to make a maximum charge £10 for supplying this information. Information held by the ACM will only be used for the internal administration purposes of the ACM unless your explicit consent is otherwise given.

## DOCUMENTS required to support your application for membership:

	Please Tick
1. I enclose my cheque for £125 which includes a £25 administration fee.	<input type="checkbox"/>
2. A certified* copy of Qualification Certificate	<input type="checkbox"/>
3. First certified* proof of identity with photo (Passport, Photo Driving Licence, Passport photo)	<input type="checkbox"/>
4. Second certified* proof of identity with address (Utility bill)	<input type="checkbox"/>
5. Copy of insurance certificate	<input type="checkbox"/>
6. Copy of current first aid certificate	<input type="checkbox"/>
7. Website Data form	<input type="checkbox"/>

\* Notes: Acceptable certifiers include bank managers, lawyers, accountants, medical doctors, senior civil servants, members of the judiciary and clergy, as well as officers of the ACM.

2. Please ask them to write 'I certify that this is a true copy of the original', print and sign their name and give the date and their position held.

3. Please ask them to write 'I certify that this is a true likeness of .....', print and sign their name and give the date and their position held.

4. Please ask them to write 'I certify that this is a true copy of the original', print and sign their name and give the date and their position held.

## Office Use Only

DATE APPROVED		CERTIFICATE NUMBER
DATE PAYMENT RECEIVED	AMOUNT	INSURANCE COVER

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