ASSOCIATION OF REGISTERED COMPLEMENTARY HEALTH THERAPISTS OF IRELAND(ARCHTI)
Ballydaniel, Camolin, Enniscorthy, Co. Wexford. Tel: 053-9383734

ADDITIONAL QUALIFICATIONS Application Form

Please complete in BLOCK CAPITALS in black/blue ink. Make sure everything is legible as your membership details depend on it.

You can use this form to update your contact details if necessary—otherwise all you need do is fill in your name and address and Membership Number.

Name (Write your details CLEARLY in BLOCK CAPITALS)

Mr/Mrs/Ms/Other _________ First Name ______________________ Middle Name _________________________

Surname____Membership Number____________

Home Address in full ____

____

Home Tel. No. ___________________________________ Mobile No. ___________________________________

Name of Your Practice ____

Practice Address in full ____

____

Practice Tel. No.________________________________ Practice Fax No. _________________________________

Website address____Email ______________________________________

The cost of adding EACH NEW THERAPY is €10 per therapy. There are **NO REFUNDS** so please make sure that your New Therapy is a valid stand-alone "complementary health therapy" and not just an "in house" module or CPD course for a therapy which you have already been registered for. *If you are not sure, please ask your Trainer before submitting it to us.*

List the Therapy/ies which you wish to ADD to those already registered ____

____

On the attached page you MUST complete the information required for EACH THERAPY you wish to be registered for as otherwise we cannot process your application. **(Please don't waste our time by listing any therapy for which you are not qualified)**

Please tick whichever of these apply:-

☐ I have insurance with the ARCHTI group scheme with Balens and I wish to ADD this new therapy/ies to my policy (please note that you will apply directly to Balens and that they may charge for this service)

☐ I have insurance with another Insurance Company and I have already added this new therapy/ies to my existing insurance policy and **I am attaching a copy** of my insurance cert.

Name of Insurance Company ________________________ Policy Expiry Date ________________

Signed:____ Date ___________________

<u>**Official Use Only below this line.**</u>

Membership No. ________________ *Date received* _____________________

Copy Insurance attached…….Yes/No. *Expiry Date* ______________

<u>Accepted</u>: YES ( ) NO ( ) *<u>Signed</u>: Membership Committee* ________________________________

*Date:*_____________________

- **If you need more space to list your therapies please copy this page and continue to list them—or you can ask us to send you additional pages.**
- **If your qualifications are not in the English Language please provide a certified translation of them.**
- **If your qualifications have been received from a non-English speaking Training Facility please contact them and have them provide you (or us) with information on who their training course is accredited by.**

Therapies for which you wish to register:

Therapy (1) ______________________________Qualifications Received ____________________

Length in Practice__________ Full or Part-time ____________________

College/Training Facility Attended NAME:____

ADDRESS:____

____

Tel No. ____________________Fax Number ____________________

Email Address ____________________Website Address ____________________

Therapy (2) ______________________________Qualifications Received ____________________

Length in Practice__________ Full or Part-time ____________________

College/Training Facility Attended NAME:____

ADDRESS:____

____

Tel No. ____________________Fax Number ____________________

Email Address ____________________Website Address ____________________

Therapy (3) ______________________________Qualifications Received ____________________

Length in Practice__________ Full or Part-time ____________________

College/Training Facility Attended NAME:____

ADDRESS:____

____

Tel No. ____________________Fax Number ____________________

Email Address ____________________Website Address ____________________

Therapy (4) ______________________________Qualifications Received ____________________

Length in Practice__________ Full or Part-time ____________________

College/Training Facility Attended NAME:____

ADDRESS:____

____

Tel No. ____________________Fax Number ____________________

Email Address ____________________Website Address ____________________

PLEASE ATTACH COPIES OF EACH QUALIFICATION—no need to take out of frame if copy is clear enough to read

PLEASE NOTE: any of the above details which cannot be verified by the Membership Committee or the Officers of ARCHTI will not be accepted for registration so it is up to the Applicant to provide as much detail as necessary in order to have theirTherapy registered.