



ASSOCIATION OF REGISTERED COMPLEMENTARY HEALTH  
THERAPISTS OF IRELAND (ARCHTI)  
Ballydaniel, Camolin, Enniscorthy, Co. Wexford. Tel: +353-53-9383734

INDIVIDUAL MEMBERSHIP APPLICATION FORM

- Please complete in **BLOCK CAPITALS** in black/blue ink.
- Make sure you complete [ALL 3 pages and sign](#) the declaration on the last page.
- Please answer ALL questions and ENCLOSE all the documents requested. [If in doubt just phone or email us.](#)
- Please read the **Rules & Regulations** document for a full explanation of the requirements on this form.

I wish to apply for membership as Full  Associate  Affiliate  Student

Mr/Mrs/Ms/Other \_\_\_\_\_ Your First Name \_\_\_\_\_ Middle Name \_\_\_\_\_

Surname \_\_\_\_\_

Home Address in full \_\_\_\_\_

Home Tel. No. \_\_\_\_\_ Mobile No. \_\_\_\_\_

Name of Your Practice (if any) \_\_\_\_\_

Practice Address in full \_\_\_\_\_

Practice Tel. No. \_\_\_\_\_ Practice Fax No. \_\_\_\_\_

Your Website address (if any) \_\_\_\_\_

Your email address (if any) \_\_\_\_\_

Tick which of the following details you would like us to put on  
your FREE listing on our Website

Practice  Home  Mobile  Email  Website  None

List the Therapies which you are qualified to practice as listed on the next page and wish us to register for you:-

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 do not hold qualifications)

STUDENTS should only list *accredited* courses which they are currently studying

If currently insured Name of Insurance Company \_\_\_\_\_ Policy Expiry Date \_\_\_\_\_

Copy of *current* Insurance Policy attached (if already insured)

I wish to apply for the ARCHTI Insurance Scheme.

Please do not write below this line—for official use only w/s

Application Fee £ \_\_\_\_\_ (£10 for up to 3 therapies—each additional therapy costs £4 each) cheque/cash/money order/draft/postal order.

Date received \_\_\_\_\_ Copy Insurance attached :-Yes/No. Expiry Date \_\_\_\_\_

Signed: \_\_\_\_\_ for Membership Committee. Date: \_\_\_\_\_

Membership Fee £ \_\_\_\_\_ cheque/cash/money order/draft/postal order. Date received \_\_\_\_\_

Memb.Granted: FULL  ASSOCIATE  AFFILIATE  STUDENT  Membership No. \_\_\_\_\_

- 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.

**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 their Therapy registered.

Name of Professional Bodies (if any) of which you are a *Current Member*:- (give FULL Name and Initials used by them)

**Please answer the following questions:-**

Are you an Irish citizen? Yes  No

Are you a Northern Ireland citizen? Yes  No

Are you an EU citizen? Yes  No

Have you Government permission to live and work in Nth. Ireland? Yes  No  Not Needed

If the answers to any of these questions is **NO** then please ask for additional forms.

**Please note** :- Non-nationals and those living outside Northern Ireland are requested to submit a reference/recommendation from your Training School/Institute or another Association of which you are a Member.

*If you have downloaded and printed these forms from the Internet or they are photocopied and you require further information before completing them please contact us and ask for details.*

The following declarations **MUST** be ticked and the form **MUST** be signed below (*otherwise your application will be returned to you or rejected*).

I am aware of the Rules and Regulations regarding Membership of the Association of Registered Complementary Health Therapists of Ireland and agree to be bound by them and further understand that if the Association at any time deems me unfit to continue to be a Member for breach thereof that Membership can be revoked and notification of same be made to all the Association's contacts.

I hereby grant permission to the Association of Registered Complementary Health Therapists of Ireland to contact any association/school/institute/training course director named above should verification of qualifications be required and in the event of same not being made available or being unacceptable shall accept that the Association has the right to refuse membership without further explanation.

I hereby grant permission to the Association of Registered Complementary Health Therapists of Ireland to contact any person/s, organisation, Government bodies, Police Forces, Military or whomsoever might be deemed necessary to investigate and verify the details contained in this application to be true.

Have you ever been convicted for unprofessional conduct or serious personal offences in Ireland? Yes ( ) No ( )

Have you ever been convicted for unprofessional conduct or serious personal offences in any other country? Yes ( ) No ( )

Are you currently under investigation for unprofessional conduct or serious personal offences in any country? Yes ( ) No ( )

If you have answered **YES** to any of the above questions please explain. \_\_\_\_\_

If you need more space please attach more pages or ask us for additional pages.

**I apply to join ARCHTI and enclose the following:-**

Copies of Qualifications

Copy of Current Insurance Policy (if already insured)

Reference (if applicable)

£ \_\_\_\_\_ **application fee** as cheque/bank draft/postal or money order made payable to ARCHTI

**Signed:** \_\_\_\_\_

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