



RENEWAL MEMBERSHIP FORM **2012**

- Please complete in **BLOCK CAPITALS**. Make sure everything is legible as your membership details depend on it.
- Please answer **ALL** questions and **ATTACH** any documents requested.
- Renewal Membership Fee is €70 and can be paid by cheque/cash/postal order/bank draft. (Sorry no online payments)

Mr/Mrs/Ms/Other _____ **First Name** _____ Middle Name _____

Surname _____

Address in full _____

Home Tel. No. _____ Mobile No. _____

Practice Name (if any) _____

Practice Address in full _____

Practice Tel. No. _____ Practice Fax No. _____

Your Website address _____ Your Email _____

***** All Full Members can have a FREE listing on our website—what details would you like there? *****

Practice

Home

Mobile

None

Your Email (Only if you open your emails)

Your Website (Only if you have one that is active)

Please tick the above boxes *accurately* as this is the only information which will be provided to prospective clients seeking therapy from you on our website. If you tick "none" or leave them blank then no information will be listed.

Please note: we **never** give your details to any outside body/individuals/organisations wishing to send bulk mailings or advertising.

If you have new therapies to be added please complete page 2 and include €10 per new therapy please and list them here:

I am enclosing the following:-

- Copy of Insurance (if your policy is not with the ARCTHI Group Scheme with Balens)
- Copy of **NEW** Therapy qualifications (if applicable)
- Membership fee of €70** (or £60 Nth. Ireland).
- Total payment enclosed _____ as cheque/bank draft/postal or money order made payable to **ARCTHI**.

Signed: _____ **Date** _____

Please **DO NOT** write below this line—Official Use Only

Renewal Fee (). New Therapies () @ 10 each = _____. Total payment _____ cheque/cash/postal order/draft.

Date received _____

Non-ARCTHI Insurance expiry Date _____

Copy of your current Insurance policy required
No Yes

Membership Number _____ Membership Category: FULL STUDENT OTHER

- If you have acquired any **ADDITIONAL** Therapies *not yet registered* for which you would like to be registered *now* please provide the details here and attach relevant supportive documentation. *If you are not insured with the ARCHTI Group Insurance scheme please attach a copy of your insurance policy showing these new therapies.* (If you are insured with the ARCHTI scheme you can apply to have these added to your existing policy once they have been accepted by ARCHTI. You will be notified when this can be done.)
- If you need more space to list your NEW therapies please copy this page and continue to list them or you can ask us to send you additional pages.
- PLEASE *do not waste our time (and your money—no refunds)* by listing therapies which are not accredited as they will not be considered. Please ensure that you are applying for a “**therapy**” and not an “in-house” or “add-on” module to an existing qualification. ***If you are not sure, please check with your Trainer before applying as there are no refunds.***
- If you have NOT yet completed your training for an additional therapy but would like to be registered and insured as a STUDENT please include it here marking it clearly “**STUDENT only**” *When you have completed your studies send us your full qualification and it will be upgraded at no additional cost.*

- **EACH *new* therapy requiring registration costs €10 (or £10 Nth. Ireland).**
- **Payment should be added to your annual renewal subscription as they will not be added until paid for.**

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 _____

You should attach a copy of **EACH** qualification—no need to take it out of frame if copy is clear enough to read

PLEASE NOTE: any of the above details which cannot be verified by the Advisory & Membership Committee 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. **No refunds.**

() I am enclosing a total of _____ representing €10/£10 for each new therapy requiring registration.

() I am enclosing a copy of my insurance policy showing these new therapies, or

() I am insured with the ARCHTI scheme and wish them to be added to my policy when accepted for registration.

Signed: _____ Date _____