



Association of Holistic and Complementary Practitioners

Application for Membership

Please complete and return this application form together with the requested documents and payment in the pre-addressed envelope enclosed to:

AHCP Limited, Old Station House, Dunsland Cross, Devon EX22 7YT

I wish to apply for the following membership category (please tick as applicable):

Practitioner Membership £55 per annum Student Membership £20 per annum

Your Details

Full Name: _____ Date of Birth: _____

Address: _____

Postcode: _____ Tel no. (daytime): _____ Email Address: _____

Business Name (If applicable): _____ Tel no.: _____

Business Address (If applicable): _____

_____ Postcode: _____ Email Address: _____

Please complete the relevant sections below and overleaf:

Practitioner Membership

Please list the relevant qualifications you have obtained together with the name of your college or training provider/s and dates of study.

Please enclose photocopies of certificates and diplomas gained, together with a photography of your Certificate of Public, Products and Malpractice Liability Insurance

(N.B we cannot process applications without these documents. If you do not currently hold insurance, please request insurance information when you return this form.)

College Name	Therapies Studied	Qualification/s Gained	Dates of study

Have you been in continuous practice since graduating? Yes No

If no, please give details: _____

Please list any other professional organisations of which you are a member: _____

Please print your name below clearly and exactly as you would like it to appear on your Certificate of membership:

Practitioner Membership Applicant Declaration (please read, sign and date the declaration below):

I wish to apply for Practitioner Membership of the Association.
I attest to the truth and accuracy of all information given in this application.
I agree to comply with the Association's Code of Practice and Membership Rules and any revision thereof which may be notified to me from time to time.
I will maintain Public, Product and Malpractice Liability Insurance at all times.
I wish to be included in the Association's Register of Practitioners and agree that my details maybe given out for referrals. (Please delete if preferred)

Signed: _____ Date: _____



Student Membership

College or Training Provider Details

Your College name: _____

Course/s you are studying: _____

Please list any other professional organisations you are a member of: _____

Student Membership Applicant Declaration (Please read, sign and date the declaration below):

I wish to apply for Student Membership to the Association. I attest to the truth and accuracy of all information given in this application.

I agree to abide by the Association's Code of Practice and Membership Rules and revision thereof which may be notified to me from time to time.

Signed: _____ Dated: _____

The Association reserves the right to refuse membership and has no obligation to disclose reasons for the decision made.

Payment details (please tick as applicable and complete the standing order form below):

I wish to apply for the following membership category:

- Practitioner Membership £55 per annum Student Membership £20 per annum.

I enclose my first year's membership fee of £ _____ and agree to pay an annual membership fee of £ _____ by standing order.

I enclose a cheque/postal order (made payable to The AHCP Limited) for the amount of £ _____

Please debit my MASTERCARD / VISA / MAESTRO (please delete as applicable) for the amount of £ _____

Card number: _____ Expiry Date: _____

Issue No. (Maestro only): _____ Security No: _____ (The three last digits on the back of your card above your signature.)

Cardholder name: _____ Signed: _____ Date: _____

BLOCK CAPITALS PLEASE

Name: (Mr/Mrs/Ms) _____

Your Bank Account number:

Address: _____

Your Bank sort code:

Postcode: _____

Please pay to Barclays Bank plc (20-65-90) for the account of AHCP Ltd, Account Number 23766594 my annual membership sum of £ _____ only, 12 months after the date shown below, and thereafter each year on the same date until countermanded by me.

YOUR BANK DETAILS

Your Bank's Name: _____

Date: _____

Your Bank's full address: _____

Signed: _____

AHCP Limited, Old Station House, Dunslund Cross, Devon EX22 7YT

Tel: 01409 220 406 Email: info@ahcp.org Web: www.ahcp.org

