



APPLICATION FORM STUDENT

| | |
|---|--------------------|
| General Information: <i>INSTRUCTIONS Please write in block capitals or type.</i> | |
| Family name: | First name: |
| Date of birth: | Place of birth: |
| Languages spoken : | |
| Sex: F <input type="checkbox"/> M <input type="checkbox"/> | |
| Are you a member of another association or gathering? Y <input type="checkbox"/> N <input type="checkbox"/> | |
| If so, the name and membership number: | |
| How have you heard about the ACTMD? | |
| Do you do house calls? Y <input type="checkbox"/> N <input type="checkbox"/> | |
| Do you offer treatments within companies? Y <input type="checkbox"/> N <input type="checkbox"/> | |
| Do you work with children? Y <input type="checkbox"/> N <input type="checkbox"/> teenagers? Y <input type="checkbox"/> N <input type="checkbox"/> | |
| Would you be interested to participate in workshops? Y <input type="checkbox"/> N <input type="checkbox"/> | |
| You would be interested to write articles? Y <input type="checkbox"/> N <input type="checkbox"/> | |
| Have you ever been recognized guilty of a criminal malpractice? Y <input type="checkbox"/> N <input type="checkbox"/> | |
| If so, specify nature and year of this malpractice: | |
| Have you been expulsed or suspended from an organism or other professional order? Y <input type="checkbox"/> N <input type="checkbox"/> | |
| If so, specify reasons as well as year of being expulsed or suspended: | |

| | |
|----------------------|-----------|
| Home address: | |
| Address: | App.: |
| City: | Province: |
| Postal code: | |

| | |
|--|-----------|
| Business address <input type="checkbox"/> Same as home address: | |
| Address: | App.: |
| City: | Province: |
| Postal code: | |

| | |
|------------------------|---------|
| Phone number(s) | |
| Home: | Office: |
| Cell phone: | Pager |
| Fax: | E-mail: |
| WEB Site: | |

APPLICATION FORM STUDENT (Continuation)

| Specialization by field of studies | | | |
|---|--|--------------------------------------|--------------------------------------|
| Massotherapy <input type="checkbox"/> | Hypnosis <input type="checkbox"/> | Naturopathy <input type="checkbox"/> | Kinesiology <input type="checkbox"/> |
| Orthotherapy <input type="checkbox"/> | NLP Master <input type="checkbox"/> | Naturopathy <input type="checkbox"/> | Homeopathy <input type="checkbox"/> |
| Kinesitherapy <input type="checkbox"/> | Chiropracture <input type="checkbox"/> | Acupuncture <input type="checkbox"/> | Osteopathy <input type="checkbox"/> |
| Others (clarify and include diplomas): | | | |

| Geographic location (choose only one) | | | |
|--|--|---|--|
| New-Brunswick <input type="checkbox"/> | Ontario <input type="checkbox"/> | North of Quebec <input type="checkbox"/> | |
| Estrie <input type="checkbox"/> | Outaouais <input type="checkbox"/> | Saguenay/Lac St-Jean <input type="checkbox"/> | |
| Gaspésie/I.D.M. <input type="checkbox"/> | Chaudière/Appalache <input type="checkbox"/> | Estrie <input type="checkbox"/> | |
| Quebec City <input type="checkbox"/> | Laval <input type="checkbox"/> | Bas St-Laurent <input type="checkbox"/> | |
| Côte-Nord <input type="checkbox"/> | Lanaudière <input type="checkbox"/> | Mauricie/Bois Franc <input type="checkbox"/> | |
| Abitibi/Témiscamingue <input type="checkbox"/> | North-Shore <input type="checkbox"/> | Laurentiens <input type="checkbox"/> | |
| Montréal <input type="checkbox"/> | Mtl/West-Island <input type="checkbox"/> | Mtl/Snowdon-C.D.N. <input type="checkbox"/> | |
| Mtl/Sud-Ouest <input type="checkbox"/> | Mtl/Westmount <input type="checkbox"/> | Mtl/Outremont <input type="checkbox"/> | |
| Mtl/Villeray-Pte. Patrie <input type="checkbox"/> | Mtl/Verdun-I.D.S <input type="checkbox"/> | Mtl/Lasalle <input type="checkbox"/> | |
| Mtl/Hochelaga-Maisonneuve <input type="checkbox"/> | Mtl/Riv. Des Prairies <input type="checkbox"/> | Mtl/St-Laurent <input type="checkbox"/> | |
| Mtl/Rosemont <input type="checkbox"/> | Mtl/N.D.G. <input type="checkbox"/> | Mtl/Centre-Sud <input type="checkbox"/> | |
| Mtl/St-Michel <input type="checkbox"/> | Mtl/Downtown <input type="checkbox"/> | Mtl/East <input type="checkbox"/> | |
| Mtl/Anjou <input type="checkbox"/> | Mtl-Nord <input type="checkbox"/> | Mtl/Plateau <input type="checkbox"/> | |
| Mtl/Ahuntsic <input type="checkbox"/> | Mtl/Mercier <input type="checkbox"/> | | |
| Others: | | | |

You must be Canadian citizen or have the right of residency




Requests from persons not born or native from Canada, please include a proof of citizenship or legal residency.

To become a student member:

- Enclose a copy or a proof of your inscription at a school accredited by ACTMD;
- Enclose a copy of your birth certificate;
- Enclose 1 current picture passport size;
- Enclose a copy of resume.



APPLICATION FORM STUDENT (Continuation)

| | |
|---|--|
| I choose to pay in one payment– For one year | |
| <input type="checkbox"/> 25.00\$ | Student member ¹ This amount will be credited to the file opening when becoming an active member |
| Total | |
| Amount to be paid: | <input type="checkbox"/> Cash / Money order <input type="checkbox"/> Cheque <input type="checkbox"/>  <input type="checkbox"/>  <input type="checkbox"/>  |
| Credit card # | Name of credit card holder: |
| Expiry date: | Issue date: |

I undersigned, certify:

- I have read and understand the terms of my adhesion request;
- I am the solicitor and that all information included in my request form are truthful and accurate;
- I assure that all the diplomas, certificates, attestations of notes, documents and information provided to the ACTMD are truthful.
- I freely consent and understand that ACTMD keeps on file all the information which I shall send in a written, oral, computerized way or any other form.
- I acknowledge that all practitioner's documents or membership certificate (s), statements are the ACTMD property. In the eventuality and for whatever reasons that I am no longer member, I engage myself to return to the head office the certificate (s), the practitioner's statements or any other documentation asked by the direction of ACTMD within ten (10) days of the cancellation of my status of member.
- It is understood that these informations remain confidential.

Date: _____ Signature: _____

¹ Fees are not refundable

