APPLICATION FORM

TITLE	SURNAME	FORENAME	D.O.B.
ADDRESS			POSTCODE
TELEPHONE	MOBILE	EMAIL	
COLLEGES / SCHOOLS			DATE QUALIFIED
THERAPIES			POST NOMINALS
PRACTICE ADDRESS (IF DIFFERENT FROM ABOVE)			TELEPHONE NUMBER
PREVIOUS / CURRENT INSURANCE COMPANY			YEARS IN PRACTICE

BEING THE SIGNATORY OF THIS APPLICATION, I AFFIRM THAT I AM IN GOOD PHYSICAL AND MENTAL HEALTH AND DO NOT HAVE A CRIMINAL RECORD OR HAVE BEEN EXCLUDED FROM ANY PROFESSIONAL REGISTER

SIGNATURE……..DATE…….

AS A MEMBER OF THE ASSOCIATION OF OSTEOMYOLOGISTS I AGREE TO COMPLETE MANDATORY CPD AS REQUIRED AND UNDERSTAND THAT THIS IS A CONDITION OF MEMBERSHIP

SIGNATURE……..DATE…….

I CONFIRM THERE ARE NO PAST OR OUTSTANDING ACTIONS / CLAIMS AGAINST ME THAT I HAVE NOT REPORTED TO THE ASSOCIATION AND THAT I HAVE NEVER HAD AN APPLICATION FOR INSURANCE DECLINED. I ALSO CONFIRM THAT THE ABOVE INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE

SIGNATURE……..DATE…….

MEMBERSHIP FEE:- THREE HUNDRED AND NINETY FIVE POUNDS {395.00} (THIS INCLUDES ONE CPD / DIPLOMA) CHEQUES MADE PAYABLE TO THE ASSOCIATION OF OSTEOMYOLOGISTS / CREDIT CARDS ACCEPTED [PLEASE CALL 0208 504 1462

PHOTOCOPIES OF QUALIFICATIONS AND CURRENT INSURANCE MUST BE SENT WITH APPLICATION FORM.
POST YOUR APPLICATION FORM TO:- **21 DANBURY WAY, WOODFORD GREEN, ESSEX IG8 7EZ**

TAO 2016